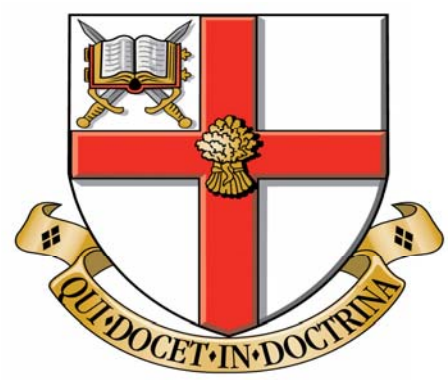

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Michael John Whitfield

Dissertation submitted to the University of Chester for the Degree of Master of Arts (Counselling Studies) in part fulfilment of the Modular Programme in Counselling Studies

November 2011

Abstract

A qualitative study is presented revisiting the work of Reeves and Mintz (2001) in exploring the experiences of counsellors working with suicidal clients and extending the focus to the issue of locus of responsibility. Following a review of the literature, semi-structured interviews were undertaken with six experienced counsellors currently or recently working with suicidal clients. These were recorded, transcribed and the material analysed using the constant comparative method (Maykut & Morehouse, 1994) to yield twelve categories representing participants experience. Themes emerging included: the impact of training, experience and organisational context, issues of client autonomy and professional responsibility, contrasting thoughts and feelings of counsellors when clients disclose suicidal feelings, ways counsellors seek to work with suicidal clients whilst dealing with their own feelings and finally, the locus of responsibility for the suicidal client and young clients especially. These are placed in context of the literature and limitations; implications for practice and further research are discussed.

Declaration

The work is original and has not been submitted previously in support of any qualification and course.

Signed:

M. J. Whitfield

Acknowledgments

I would like to thank the following for their help in completing this study:

- The six participants, who so generously gave their time to allow me to interview them, for their openness and honesty in offering their experiences.
- Those who agreed to display or pass on recruitment posters in their organisations.
- Dr Rita Mintz, Tony Parnell, Anne Le Surf and subject librarians Kirstie Preest and Charlotte Gleeson from the University of Chester for their advice and support.
- Diane Fitzsimmons for being my pilot interviewee.
- Dr Laurie Craigen from Old Dominion University, Norfolk VA, for sending me a copy of her article.
- Lesley and Peter Brown for printing the final version and for their help and support
- Finally to Dr Andrew Reeves for his unending support, advice and encouragement as research supervisor over the last two years.

Contents

List of Abbreviations

BACP –	British Association for Counselling and Psychotherapy
BPS –	British Psychological Society
CBT –	Cognitive Behavioural Therapy
DBT –	Dialectical Behaviour Therapy
IAPT –	Improving Access to Psychological Therapies
EAP –	Employee Assistance Programme
MS –	Microsoft
PDF –	Portable Document Format
RTF -	Rich Text Format

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Chapter One: Introduction

> *Some of the situations which counsellors encounter cause great anxiety. Working with clients who are seriously intent on suicide must be one of the most anxiety provoking because of the sense of imminent death, which makes any decisions and actions irreversible. The choice between life and death is a stark one. At a time when the counsellor's therapeutic skills are being considerably tested, there are also major ethical issues to consider. The counsellor is faced with a choice between respecting the client's autonomy or seeking to preserve life either because this is a fundamental ethical principle or because it is thought to be in the client's best interests.*
> *(Bond, 2010, p. 101)*

Client suicide has been described as an occupational hazard for psychologists and psychiatrists (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989) and is the 'client crisis most frequently encountered by mental health clinicians' (McAdams & Foster, 2000, p. 107) while Werth and Liddle (1994, p. 440) state that 'The vast majority of practicing psychotherapists will have a client attempt and/or commit suicide some time in their careers'. Reeves writes that of over three thousand counsellors he has met delivering a training programme for working with suicidal clients that 'Barely any… did not have some experience of working with suicide potential…' (Reeves, 2010, p. 4) and, '…if we relate counselling agencies to suicide risk factors – bereavement, relationship breakdown, psychopathology, physical health problems… virtually all counsellors would have some profile of suicide potential...' (Reeves, 2010, p. 3). While counselling has become increasingly available in primary and secondary care, multi-disciplinary mental health teams and in schools and colleges, it seems reasonable to assume that the more people who access it, the more counsellors will encounter clients with suicide potential.

However, the literature indicates that training on counselling courses around working with suicidal clients is inadequate and a cause of anxiety for counsellors (McAdams & Foster, 2000; Reeves, 2004; Reeves & Mintz, 2001) and one study indicates there is considerable variation in when counsellors chose to break confidentiality, implying individual factors play a major part in the decision making process, rather than training or context (Moyer & Sullivan, 2008). It would therefore seem appropriate to examine what these individual factors might be; what is the internal process for counsellors in these stressful situations, what influences might there be from their beliefs and experiences, their training and their organisation.

The one study focusing on this area is ‘Counsellors’ Experiences of Working with Suicidal Clients’ (Reeves & Mintz, 2001). As this was an exploratory study, conducted over ten years ago, and nothing like it appears to have been undertaken since, it seems appropriate to revisit this area, following the same qualitative methodology, without replicating in the way one would using a quantitative paradigm. It will be interesting to see what evolutionary development has occurred with the passage of a decade and to further shed light on an important and overlooked area. As Reeves himself notes, ‘In research terms, very little attention has been given to the counsellor.’ (2010, p. 135).

However, in reviewing the literature it became apparent that the issue of responsibility is of central importance in the relationship between the counsellor and the suicidal client. The extent to which the counsellor feels the need to take responsibility for the client affects the dynamics of the therapeutic relationship, the effectiveness of the therapy and the emotional impact upon the counsellor. The literature suggests practitioners may take on more responsibility than is efficacious, that this can be counterproductive in taking responsibility and control from the client and potentially damages the therapeutic alliance. Furthermore, this high level of responsibility can impact negatively upon the counsellor emotionally but is out of proportion to the influence the counsellor may have in determining the fate of the client. The counsellor’s beliefs toward suicide, and consequentially perhaps, their therapeutic orientation (Skovholt & Ronnestad, 1992) as well as fear of legal and ethical sanctions can determine the amount of responsibility the individual counsellor takes, up to and including breaching confidentiality, maybe against the wishes of the client. It is this issue, therefore, upon which this study will focus, within the experiences of counsellors working with suicidal clients.

Chapter Two: Literature Review

In addition to electronic databases I used textbooks on the subject and on methodology. A summary of the search strategy is in Appendix I.

Areas covered in the literature:

- Assessment of suicidal risk/ risk assessment generally
- Therapeutic process in working with suicidal clients/ therapeutic orientations
- Impact of client suicide upon the counsellor/ therapist
- Impact of suicidal clients generally: attitudes toward suicide and suicidal clients, experience, coping strategies, support, training or lack of training
- Client capacity for making informed decisions around suicide, the 'rational suicide' issue, counsellors'/ therapists' views on this.
- Ethical, boundary and legal issues- especially relating to U.S. law in which there is more expectation of the professional to prevent suicide, the 'duty to protect'.
- 'No-suicide' contracts, pros and cons, use and effectiveness of.
- Issues relating to suicide within specific client groups e.g. AIDS patients, or settings, e.g. schools, prisons

BACP Systematic Review

In 2009, the British Association for Counselling and Psychotherapy published 'Counselling and Psychotherapy for the Prevention of Suicide: A systematic review of the evidence' (Winter, Bradshaw, Bunn, & Wellsted, 2009). This considered the effectiveness of counselling and psychotherapy with suicidal people and the process. It demonstrates that the literature is dominated by studies of quantitative methodology and a focus on a narrow range of non-humanistic therapies. The fact that Winter et al felt it necessary to include more non-randomised and qualitative studies to balance out the weight of randomised controlled trials and shed more light on therapeutic process and facilitators and barriers to therapy, acknowledges the paucity of research in this area.

'Process': Therapist Variables

Gurrister and Kane (1978) found working with suicidal clients evoked anxiety, anger and frustration as well as concern and protectiveness. Neimeyer, Fortner, & Melby (2001) found an attitude which accepts death and a belief in the unacceptability of suicide were positively correlated to suicide intervention competency- although this is not well defined- and Winter et al (2009) suggest training needs to incorporate therapists' attitudes toward death and suicide. Davidson et al (2004) found therapist competence - adherence to therapeutic model, skill level and interpersonal effectiveness - correlated with a reduction in depressive symptoms but unrelated to age, gender or professional qualifications. Winter et al, while acknowledging methodological issues with this study, suggest it implies appropriate training is sufficient for an effective intervention. In contrast, Winter et al cite Modestin, Schwarzenbach, & Wurmie (1992) as suggesting therapists' experience correlates with lower rates of client suicide. These studies emphasise the importance of experience and training, especially incorporating the therapist's own views on death and suicide, but the evidence is insufficient to draw definite conclusions.

Several studies focused on young people. Storey, Hurry, Jowitt, Owens, & House (2005) found young people resented therapists with their own priorities and agenda at the expense of the client's concerns, though methodology is unclear. Paulson & Everall (2003) examined which aspects of therapy suicidal young people found helpful and found maintaining a strong therapeutic relationship based upon respect, understanding and acceptance to be most important along with treating the individual as a whole rather than concentrating on suicidal behaviour. The participants were 83% female and the recruitment process and therapeutic approach are unclear. These studies back the importance of the therapeutic relationship over adherence to theoretical model, or undue focus on specific issues, however, given their young and predominantly female participants, generalizability is limited.

In terms of important variables when treating suicidal people, Winter et al (2009) cite Kate Davidson, Livingstone, McArthur, Dickson, & Gumley (2007) and suggest this study may show therapists feel they have to work harder with clients who show little improvement to provide justification for the lack of progress and suggest therapists could be trying to alleviate guilt. This study focused on CBT and 85% of participants

were female, however, it emphasises the importance of understanding the therapist's internal psychological processes and their impact.

Qualitative Studies

This section explores clients and therapists views on the process and effectiveness of therapy and also barriers and facilitators. Studies by Reeves and Mintz (2001) and Reeves, Bowl, Wheeler, & Guthrie (2004), although criticised methodologically and felt to make a small contribution overall, are cited as important for highlighting areas not addressed elsewhere, specifically lack of support and training.

Responsibility was seen as a barrier by counsellors but a facilitator for clients. Reeves and Mintz (2001) and Reeves et al (2004) found counsellors felt forced to conform to professional boundaries even though they conflicted with their personal beliefs on the right to suicide. This may impact upon therapeutic effectiveness and was not dealt with adequately in supervision. Clients, especially those in DBT, felt taking responsibility for making changes was important in therapy. 'Counselling is only helpful if you actually want to change or get help' (Craigen, cited in Winter et al., 2009, p. 50). One might speculate that the structured and institutional nature of DBT may make clients and therapists feel comfortable in the client taking on more responsibility as risk can be better managed.

Reeves and Mintz (2001) found lack of training and resources for dealing with suicidal clients caused anxiety for counsellors and this could lead to avoidance of the subject of suicide. Rubenstein (2003), in a study meeting six out of seven of Winter et al's quality criteria, is cited as finding that for psychoanalysts, the threat of suicide can disrupt the therapeutic process and that the client may even hide their suicidal feelings to 'protect' the therapist.

Winter et al (2009) identified support as a major facilitator of therapy. This was found lacking in suicidal clients' lives and when this was apparent in therapy it was linked to the client's quality of life and a renewed sense of hope, which both Dahlsgaard, Beck, & Brown (1998) and Barbe, Bridge, Birhamer, Kolko, & Brent (2004) found to be positively correlated with reduced suicide potential. 75% of participants in the Barbe study were female, flagging up the possibility of gender bias.

Counsellors' Experiences of Working with Suicidal Clients: Reeves and Mintz (2001)

The study which focuses most upon the research question is Reeves and Mintz (2001). They found counsellors experienced a range of distressing emotions when working with suicidal clients, such as anxiety, fear, panic and impotence. They felt ill prepared by their training, doubted their competence and ability to practice safely, and felt their work was dictated more by organisational policy and fear of litigation than by therapeutic judgement. This was a particular issue for those accepting of suicide, who felt coerced into breaking confidentiality against their beliefs, feeling they had 'betrayed' their clients in doing so. Yet there was also the need to break confidentiality in certain cases to protect clients from themselves. Risk assessment and contracting were carried out in an informal and ad hoc way.

A number of methodological issues regarding this study were raised by Winter et al (2009) , which I have aimed to address in revisiting it. Specifically, they felt that the context of the study and nature and recruitment of the sample were only partially explained, methodology around the collection and analysis of data were unclear, no attempts had been made to establish the reliability and validity of the data analysis and there was insufficient original data included.

Richards (2000), working from a psychoanalytic perspective, also examined the effects on psychotherapists of working with suicidal clients and found '…feelings of hopelessness and helplessness; a sense of failure; feeling upset, distressed and sad; anxiety…' The need for support and supervision were emphasized along with the dangers of inexperience. A finding also was the realisation that therapists are not omnipotent and that despite one's best efforts, client suicide is still possible. Birtchnell (1983) notes similar emotional reactions in therapists and suggests this leads to dilemmas of dependency and responsibility for the therapist.

Training and Support

As Reeves and Mintz (2001) and Reeves et al (2004) noted, one cause of counsellors' anxiety is lack of training and support. McAdams and Foster (2000) in an

extensive survey of U.S. counsellors, also emphasise the need for training around suicide as part of counsellor education.

Personal Characteristics of the Counsellor/ Therapist

It seems there is more here than a stressful situation for which the therapist feels unprepared and ill supported. Moyer and Sullivan (2008) in a study which acknowledges a poor response rate and an unpiloted, non-validated instrument, found considerable individual variation in when counsellors chose to breach confidentiality. This implies the personal characteristics of the counsellors play a large part in decision-making as opposed to contextual factors and professional training and therefore underlines the importance of a qualitative approach to investigate the counsellor's process.

A number of studies show the importance of the counsellor's own attitude toward death, dying and suicide, e.g. Bernstein (2001), Lussier (2005), in their work with suicidal clients and their effectiveness (Roose, 2001). Barry (1984) believes it is important that therapists be aware of their attitudes and how they might impact upon client work, a view echoed by Rycroft (2004). Bernstein suggests these attitudes could be selfish, relating to the effect the other's death will have on us. Orbach also notes the potential for incapacitating anxiety arising from therapists' own feelings:

> *It is not only the sense of responsibility for another person's life that is incapacitating in this work, but mostly it is the therapist's "own suicidality," death anxiety, fear of hopelessness, and mental pain... (Orbach, 2001, p. 171)*

Hendin, Haas, Maltsberger, Koestner, & Szanto (2006, p. 67) talk of '…ineffective or coercive actions resulting from the therapist's anxieties…', while Roose (2001, p. 151) suggests 'the fear of shame and failure' can negatively impact upon the therapist's ability.

Other therapist factors can influence working with suicidal clients. Gurrister & Kane (1978) found previous experience of client suicide can make therapists more protective and more directive in approach, while Cummings & Thompson (2009), writing about a prison population, highlight the danger of regarding the suicidal as

‘manipulative’ and thereby failing to treat someone research has demonstrated is at risk of suicide.

Those not accepting of suicide can have countertransference anger toward the client for rejecting life (Maltsberger & Buie, 1974) and their help (Milch, 1990) and these feelings prevent the development of empathy, which is counter productive (Orbach, 2001). However, Neimeyer et al (2001) found a history of suicidality and a belief in suicide as a right to be negatively correlated with suicide intervention competence, whereas ‘death acceptance’ was a positive, along with levels of training and experience. Interestingly, Brown & Range (2005) found trait anxiety in crisis helpline workers was facilitative to competence, although how this might operate is unclear.

The Attitudes and Expectations of Society

In the UK, a number of government documents, beginning with ‘Saving Lives: Our Healthier Nation’ (Department_of_Health, 1999b), continuing with the National Service Framework for Mental Health (Department_of_Health, 1999a) and the National Suicide Prevention Strategy for England (Department_of_Health, 2002), express the intention to prevent and reduce suicide. Reeves (2004, 2010) states this makes suicide prevention a priority for therapists regardless of work context. We can see therefore how the national legal and policy environment within which counsellors and other mental health professionals work, exerts pressure, via the vehicle of organisational policy, upon practitioners.

The Effects of Pressure on the Therapeutic Relationship

Ellis (2004) notes the heavy responsibility placed upon the therapist to succeed with suicidal clients and outlines how the therapist’s stress leads them to need to control client behaviour, leading to resistance and the loss of potential collaboration. Hendin (1981, p. 469) argues ‘Psychotherapy can be successful with suicidal patients if the therapist does not reduce therapy to management and control…’. An empathic, person-centred (Leenaars, 2004) accepting approach with suicidal clients appears to be more efficacious and preferred by clients (Thomas & Leitner, 2005) than one reliant on power and control (Streicher, 1995). Sharry, Darmody, & Madden (2002), writing from a solution-focused perspective, argue for a collaborative response, while Jobes, Moore, & O'Connor (2007) outline a collaborative and implicitly ‘client-centred’

model of working with suicidal clients and Plakun (2009) argues for the importance of the therapeutic alliance.

The Issue of Responsibility

Wildman (1995) found therapists of varying orientation were more likely to blame the 'therapeutic failure' of client suicide on the therapist than client factors (client suicide is defined as a 'negative therapeutic outcome', and it is unclear whether this is a prior opinion or merely a reporting of the findings), while Stern (1985) argues for recognising the limits of the role of psychotherapists in determining the client's fate. Trimble, Jackson, & Harvey (2000), surveying over four hundred clinical and counselling psychologists, concluded successful coping with suicidal clients was realising client responsibility, while Olin (1976), writing on the chronically suicidal, regards the assumption of responsibility as a 'therapeutic disaster'. Cummings, Cummings, & Pallak (1996) suggest taking responsibility is one of four 'outmoded attitudes' leading to therapeutic mismanagement. Whittinghill, Bordeau, Whittaker and Lusk (2008) elaborate the danger of assuming responsibility for one's clients and the breach of professional boundaries by relating the tale of a counsellor who feels 'solely and excessively responsible for his clients' and allows them to phone him at home (Whittinghill et al., 2008, p. 77).

It seems possible therefore that assuming too much responsibility could be counterproductive to therapy and might result in the feelings of impotence and inadequacy felt by Reeves and Mintz's (2001) counsellors - feelings which one study suggests may be misplaced. Tekavcic-Grad & Zasnikav (1987, p. 162) found counsellors on a Yugoslav telephone crisis line 'were much more critical of themselves and less satisfied with the help they offered, feeling it was often insufficient and less effective than the callers perceived it.' Uhlmann (2003), reporting case study material suggests even though treatment may appear to fail and suicide seem inevitable, the patient can in fact thrive.

Conclusion

Overall the literature appears to suggest negative emotional responses experienced by counsellors and therapists encountering suicidal clients stem from a number of

sources, the expectations placed on them by society via their professional standing and the fear of being held responsible for a 'failure'; the lack of training and support in dealing with such difficult situations and the conflict with their own personal attitudes and beliefs. These feelings in the counsellor impact upon work with the suicidal individual, often with negative therapeutic consequences. The key concept that emerges is one of locus of responsibility. The role of counsellor seems to demand one takes on a degree of responsibility for a client who is, in being a client, vulnerable, especially so if suicidal, as the perception is one will be blamed if they kill themselves.

> *If we suggest that suicide is preventable… we will be held potentially accountable for deaths that occur during our watch. It is an awesome responsibility we have accepted. (Berman, 1998, p. 55)*

However, it would appear that accepting too much responsibility can be counterproductive to therapy, compromise the trust and agency of the client, robbing them of the opportunity to engage in their own recovery, and that a strong therapeutic relationship based upon a client-centred and collaborative approach is not only more effective for the client, but less stressful for the counsellor.

Although there is much research that is pertinent to this area, they are often studies specific in their focus on client group, context, therapeutic orientation and professional role, sometimes with questionable methodology, and that the extent to which we can regard those findings as applicable outside their narrow focus, is limited. There is much literature which is tantalising in what it suggests but very little which concentrates on the area of the Reeves and Mintz (2001) study - the experiences of counsellors working with suicidal clients - and which uses a methodology capable of capturing the internal processes of those counsellors. It seems vital to understand these processes better as they appear to have such influence on work with suicidal clients and they impact not only on the outcome of therapy but take a toll on counsellors.

It is therefore justifiable to revisit the work of Reeves and Mintz after a decade, with little comparable research having taken place since, to see whether anything has changed, and focus additionally on the issue of responsibility which the literature has highlighted as important.

Chapter Three: Methodology

Design

A qualitative methodology was chosen as most suitable, in order to look in depth at the experiences of individual counsellors in therapeutic interactions with suicidal clients, in which they must grapple with complex issues involving their own personal beliefs, professional competence, risk assessment, client capacity for making judgements and possible legal and ethical sanction. Textbooks on the subject (Bond, 2010) admit there are few clear answers and decision making comes down to informed judgement. The scale, complexity and personal nature of the processes involved demand a phenomenological methodology which recognises the uniqueness of experience and meaning and seeks to explore and describe rather than quantify and generalise (Silverman, 2005).

The study to be revisited (Reeves & Mintz, 2001) employed a qualitative methodology for similar reasons, and it is logical to follow suit (Silverman, 2005). Also, as a person-centred trained counsellor, my core philosophy is phenomenological, based upon the uniqueness of experience and the suspension of objective truth to comprehend as far as possible the experiences of another (McLeod, 2003). This, combined with my ability as a counsellor to 'bracket' (Patton, 2002) my own attitudes and beliefs as far as possible should help minimise bias (Patton, 2002) - important given my personal and professional experience and opinions on the subject.

A qualitative framework allows the use of a flexible (Robson, 2002) or 'emergent' (Patton, 2002) design, responsive to the evolving research process and adaptable to take into account incoming data and the researcher's experiences. I therefore kept a research journal (Maykut & Morehouse, 1994), (Robson, 2002) to make note of ideas, themes and experiences as I conducted the study. This informed the 'Discovery' phase of data analysis (Maykut & Morehouse, 1994).

Trustworthiness

Maykut and Morehouse (1994) suggest ways researchers can give confidence in the outcomes of their studies. The first is using multiple methods of data collection to demonstrate the phenomenon is being understood from different perspectives. Interview data have been used, backed up with a literature survey. Secondly, an audit trail allows anyone to follow the same path and understand how conclusions have been reached. This involved a documented, systematic review of the literature, the use of established methodology, standardised research materials, a research journal, a sufficient quantity of original data and a fully documented data analysis procedure. Thirdly, although not undertaken by a research team, the study has been overseen by an experienced, well-qualified supervisor who has provided advice and support. Fourthly, 'Member Checks' (Lincoln and Guba, cited in Maykut & Morehouse, 1994), were conducted, whereby participants' feedback on the outcomes was sought and incorporated into the results.

Materials

A poster was designed (see Appendix II) to recruit participants. This contained details of the study, participant criteria and contact details. It was saved in PDF format so that it could be sent by email and printed off.

An Information Sheet (see Appendix III) was produced giving fuller details, the focus of the study, that participation was voluntary, that it was possible to drop out up until the work was submitted, what information would be taken in what form (questionnaire and audio recorded interview), that this information would be held securely, treated in confidence and that no identifying information about participants or their organisations would be included in the research or subsequent publications, and what would happen to written records and audio recordings (kept for five years by requirement of the University and destroyed upon completion of the research respectively). The Information Sheet was written with the ethical codes of both the researcher's professional organisations in mind, BACP and BPS, in addition to that of the University of Chester, and in consultation with the supervisor.

A questionnaire (see Appendix IV) was designed to gather basic information about potential participants to inform the study and aid the purposive sampling process. This largely followed Reeves and Mintz (2001), in containing information about the study and contact details and took the following information: time working as a counsellor, working environment, professional qualification, current client load, theoretical approach, number of current suicidal clients, whether suicide or self harm are referred to in client contracts, confirmation of current supervision, which ethical code they work to, a space for additional comments and contact details and whether they would be prepared to participate in an interview. In consultation with the supervisor, demographics like age group, gender and ethnicity were added, the range of theoretical approaches was expanded to reflect current trends, as were the options for length of time working as a counsellor post-qualification. Options for working environment were expanded to include IAPT and EAP and the question 'How would you define 'suicide' with respect to work with clients?' was dropped as this did not gather quantitative demographic data about participants to enable purposive sampling, had not generated a great deal of information in the original study and would be covered in the interviews. The questionnaire was designed as hard copy and also electronic RTF format that could be emailed, filled in on screen and emailed back. This would reduce costs, make the process easier, and therefore increase the rate of return.

Interview materials were designed, firstly, an interview guide (see Appendix V). It is important to use an interview guide to keep interviews focused (Patton, 2002) and as a means of standardisation ensuring the same areas are covered for each participant, increasing reliability and trustworthiness (Silverman, 2005). However, this allows freedom to explore each participant's own experiences, which a structured approach might stifle. The guide followed that of Reeves and Mintz (2001) with the addition of questions focusing on the issue of responsibility derived from issues raised by the literature: how much responsibility participants felt they took for clients generally, how this changed when clients said they were suicidal, how much responsibility they felt they should take for a suicidal client, how effective they felt this was, and what they felt would happen if they were to take more responsibility. A standardised interview introduction was written, to be read to all participants (see Appendix VI), following substantially that of Reeves and Mintz (2001). This restated the aims and purpose of the interview, the topic areas to be covered, asked

participants to confirm the number of suicidal clients currently worked with and that they were in on-going supervision. It restated the intention to audio record and transcribe interviews, how materials would be kept secure and treated as confidential, that no identifying information would be contained within the transcript, who would have access to the materials and that participants could withdraw up to the submission of the work. A consent form for audio recording was written (see Appendix VII), following that from the original study, restating the purposes the recording and transcript would be used for, who would have access and the levels of confidentiality and security used in handling and storage.

Recruitment

As with the original study and the requirements of the University Ethics Committee, participants were to be qualified counsellors with at least three years' post qualification experience, in on-going supervision and currently or recently working with suicidal clients. To prevent 'dual relationships' biasing the data, the committee stipulated participants should not be from the researcher's place of work. As it would be necessary to visit participants to interview them, the geographical area for recruitment was restricted. Two methods were employed, an advert in 'Therapy Today' magazine, and the researcher's and supervisor's contacts. These comprised counselling agencies and counselling departments at universities and colleges, including the University of Chester. The recruitment poster was emailed to named contacts where possible who were asked to forward it to others who might be interested.

Participants/ Sample

The intention was to conduct four to eight interviews to keep the workload manageable and to draw participants from a pool of respondents in a 'purposive' (Maykut & Morehouse, 1994) manner using questionnaire data. In quantitative research, random sampling is used to ensure the sample is an accurate representation of its population so that the results are generalizable. In qualitative methodology, the aim is 'gaining a deep understanding of some phenomenon experienced by a carefully selected group of people' (Maykut & Morehouse, 1994, p.

56). Patton (2002) elaborates strategies aimed at increasing understanding versus generalizability of results. Extreme cases may be sampled as especially illuminating, typical cases sampled as it would be impractical to sample atypical ones, or critical cases sampled where they subsume the larger phenomena. However, Maykut and Morehouse suggest the most useful strategy is 'maximum variation' sampling, whereby participants are selected to represent the greatest differences in the phenomenon, and this was the intention in this study.

Participants would be a 'carefully selected group of people' in that they would be experienced counsellors currently or recently having worked with suicidal clients. Person centred counsellors had been advertised for, as all Reeves and Mintz participants had been this orientation and it had been felt wise not to introduce another variable. Given the person-centred philosophy places such emphasis on the individual as the primary reference point and stresses 'the *importance of rejecting the pursuit of control or authority* over other persons', Bozarth and Temaner Brodley cited in Mearns and Thorne (1999, p. 19 [italics in original]), counsellors schooled in this approach will struggle most with taking responsibility for clients and are likely to have the richest and most revealing experiences.

Seven emails expressing interest were received, resulting in six completed questionnaires. One respondent came from an institution contacted directly and only one via the 'Therapy Today' advert. The rest presumably came from emails forwarded by primary contacts.

Although sufficient participants had been recruited, there was a dilemma; choose four or five of the six using the questionnaire in a purposive manner, which would demonstrate that participants had been chosen to provide 'maximum variation' or interview all six, which would give more data but cease to be a purposive sample and become an opportunity or convenience one (Coolican, 1994) and of lower quality.

It was decided to interview all six as this was within the parameters set for numbers, the low response rate had reduced the representativeness of the pool of participants, and, as became apparent, there were reasons the majority of participants had self-selected themselves which could be built into the design.

Table 1 below shows participants' questionnaire data:

Table 1: Interview Participant Information

No	M/F	Age Group	Therapeutic Approach	How long since Qulification?	Working Environment	Predominant Client Group	Current clients	Suicidal Clients
1	F	45 - 54	PCT	3 - 5yrs	LA (FE)	16 - 19yrs, some adults	20 p/w	Variable throughout the year
2	F	45 - 54	INT	9 - 10yrs	LA (FE/HE)	Student counselling, all ages, predominantly mature	16 current, 70 per year	3
3	F	45 - 54	INT	11 - 15yrs	FE	16 - 19yrs old	10 - 12 p/w	6 approx in last 3 months
4	M	45 - 54	PCT	9 - 10yrs	LA, VA, PP	Local Authority staff	2 current	1
5	F	45 - 54	INT	6 - 8yrs	LA (FE/HE), PP	Students from FE/HE college, 16yrs+, mixed ethnicity	25 current	5
6	F	35 - 44	INT	6 - 8yrs	NHS, IAPT, HE	Adults	25 current	1

All Participants described their ethnicity as white, white British or white UK and all stated that they followed the BACP Ethical Framework

There were five females and one male, five fell into the 45 – 54 age group, with one in the 35 – 44. Four out of six described their therapeutic approach as Integrative (INT) and two as Person Centred (PCT). Average experience lay in the ranges 6 -10 years, the lowest being 3 – 5 and the highest 11 – 15. Five worked in several contexts, with Local Authority (LA) being the most common, although for all but one, this was further and/ or higher education (FE, HE). Two also worked in private practice (PP), one in a voluntary agency (VA) and one within the NHS and an IAPT service. Four worked predominantly with students, an additional one having just started and three of these worked predominantly or exclusively with 16 -19 year olds. Current client load varied between two and twenty-five, with suicidal clients being between one and five, whilst those without current suicidal clients estimated numbers worked with recently or typically. All participants described their ethnicity as white, white British or white UK and followed the BACP ethical framework.

Data Collection

The primary means was in depth semi-structured interviews of participants as in the Reeves and Mintz study, utilising the same questions but with the additional focus of the issue of responsibility.

Pilot interview

The interview was first piloted with a colleague who fitted the criteria for participation but was unable to participate owing to ethical considerations. This allowed testing of the interview process, the Reeves and Mintz interview guide and the recording equipment. It would give sample material to transcribe and practice looking for 'units of meaning' (Maykut & Morehouse, 1994). This proved a useful experience in the feedback given, and the researcher's feelings carrying out the interview. As a result , the Reeves and Mintz interview guide was changed. The first section 'Working environment/ Context' was expanded to ask whether the participant conducted assessments as well as counselling and the differences between these assessments and the first counselling session and asking how they went about risk assessment and how important they felt it was. This enabled a greater focus on the assessment process, specifically risk assessment, and refined the original guide rather than deviating from it. In the second section, 'Counselling Agreements/ Contracts', the order of the questions was changed into a more logical sequence. In the section 'Own views and beliefs' the final question on the impact of training was refined to ask whether suicide was dealt with in training as it had been a finding of Reeves and Mintz (2001) that counsellors felt training to be inadequate. The section 'When a client says they are suicidal…' was split into two distinct parts focusing on thoughts and feelings separately. Neither interviewee or researcher felt this allowed the interview to 'flow' at as it was difficult to separate out the experience into thoughts and feelings, so the two parts were amalgamated and the questions reordered into a more logical sequence. No other changes were made to the interview guide, other than adding the section on 'The Issue of Responsibility' prior to the pilot interview.

Interviews

Arrangements were made to interview the participants, all of which were carried out within a confidential space, usually their own counselling room at their place of work. It had become apparent that a high proportion of participants worked in the education sector, often with 16 – 19yr olds and it was important to see if this was an artefact of recruiting indirectly through educational institutions or something else. Participants were therefore asked prior to the interview questions proper, what their motivation had been for participating and these responses form part of the analysis.

Using a semi-structured format ensured a degree of consistency in that the same subject areas were explored with each participant and in the same order. However, there was sufficient flexibility to allow further exploration in response to the participants' material. It was important here to bracket the researcher's own experiences lest they inadvertently direct the questioning or colour the participants' responses.

Interviews were recorded on a digital recorder using an external microphone. At the beginning of each recording the standard introduction was re-read and the participant asked if they were happy with these arrangements as an additional measure of informed consent. The date, time and location of the interview, researcher's and participant's names were recorded, in order that recordings would be identifiable, although all identifying information was removed in transcription. The audio files were then uploaded onto a computer for secure storage.

Analysis

A qualitative methodology was followed in line with the original study and the researcher's philosophy and training. Reeves and Mintz used the 'constant comparative method', originated by Glaser and Strauss, cited in Maykut and Morehouse (1994), whose version of the method has been followed, as Reeves and Mintz did. In contrast to the positivistic scientific method which follows a deductive process, qualitative research operates on an inductive model where data are collected on a focus of enquiry and analysis allows themes or categories to emerge by a process of inductive reasoning. Following a defined methodology enhances the validity and trustworthiness of the findings of research as it allows others to see how conclusions are arrived at, and if desired the path can be traced back to the raw data whence they emerged (Maykut & Morehouse, 1994). Data must therefore be converted into an easily readable form and coded so as to remain identifiable throughout the analysis process.

Audio playback software was used to transcribe all six interviews into MS Word, identifying information removed and the initials 'M' used for researcher and 'P' for participant. Page and line numbers were added so that an audit trail (Lincoln and

Guba, cited in Maykut & Morehouse, 1994) could be used for purposes of replicability, ensuring once data analysis begins, any piece of data subsequently moved and re-categorised can be traced directly back to its source.

A decision was taken not to engage in formal data analysis until the interviews and transcription were complete, despite already being in the 'discovery' phase (Maykut & Morehouse, 1994), themes being noted in the research journal and Maykut and Morehouse suggesting data analysis begin whilst data collection is on-going. This was practical in that travelling to interviews and transcription were time consuming; however, it was also felt there was a danger of subconsciously biasing subsequent interviews as there would be an awareness of categories emerging from the analysis which would be difficult to 'bracket' (Patton, 2002).

The data was next divided into 'chunks' or 'units' of meaning (Marshall, and Lincoln and Guba respectively, cited in Maykut & Morehouse, 1994). Although following the *method* of constant comparison, paper copies of transcripts cut and pasted onto index cards were not used. In line with Robson (2002) and Silverman (2005), data analysis was conducted using word processing and spreadsheet packages, MS Word and MS Excel. This was less intensive in terms of labour and space and was more intuitive to the researcher, being more comfortable working on a computer.

Instead of drawing lines to demarcate units of meaning on photocopied transcripts, labelling them appropriately as to their origin in the transcript, then cutting them out and pasting them onto index cards with a word or phrase indicating the meaning, each transcript was gone through using the highlight tool to highlight text representing the unit of meaning identified. The relevant section was copied, including sufficient surrounding text to give context onto a separate spreadsheet, indicating the participant, page and line numbers in adjacent columns and then the word or phrase indicating the unit of meaning (See Appendix VIII).

The next stage was discovery and inductive category coding (Maykut & Morehouse, 1994). A second spreadsheet was created to hold recurring topics and phenomena in the data that were beginning to emerge from reading and unitising transcript data, informed by the research journal. As the process of 'constant comparison' was begun, each unit of meaning was examined in comparison to the others, and, in an

adjacent spreadsheet column, labelled with which category, or indeed categories, it most looked or felt like it belonged to, (Lincoln and Guba, cited in Maykut & Morehouse, 1994). If it appeared not to belong to any existing category, a new one was created on the second spreadsheet and labelled with that. This process continued, with categories being renamed, merged or removed as necessary as more units of meaning were analysed.

Continuing to analyse units of meaning in this way, a list of eighty-one provisional categories was reduced to twelve, which subsumed the provisional categories as higher level or 'meta' categories. In analysing the units contained within them, 'rules of inclusion' or propositional statements (Maykut & Morehouse, 1994) were created summarising the meaning contained within. Remaining data were now categorised using these 'rules of inclusion', rather than the more intuitive 'look/feel-alike' method (See Appendix IX).

Member Checks

In line with Maykut and Morehouse (1994) as a further measure to increase validity and trustworthiness, the list of twelve 'meta categories' and rules of inclusion was emailed to the six participants, and feedback requested on how they felt their experience was represented in them. Reeves and Mintz (2001) did not do this and this was an improvement on their methodology.

Responses were received from five out of six participants (83.33%). On the whole they were positive, however, two participants stated that one or more individual categories were contrary to their experiences. This would seem to be inevitable given the methodology rather than evidence of systematic bias or errors. By the nature of the process of inductive category coding and assigning units of meaning, categories will emerge more strongly the more participants produce units of meaning fitting them. This would mean a theme could emerge from a majority or even proportion of participants that did not fit the experiences of some of the others. One could not, nor should not expect all the categories to reflect the experiences of each individual participant but their experiences as a whole, what Maykut and Morehouse (1994) call a 'reasonable' reconstruction of the data.

However, Silverman (2005) argues for ‘comprehensive data analysis’ where all data are incorporated into the analysis and that it is only in actively seeking out and addressing anomalies that this can be achieved and validity strengthened. The issues raised by these participants are addressed in the Discussion in an attempt to reconcile these ‘deviant cases’.

Ethics

Given the researcher’s status as a counsellor and member of BACP and also as a Trainee Counselling Psychologist and member of BPS, these ethical codes were followed in conducting research, around the issues of informed consent, confidentiality and data protection. Approval was gained to carry out this study from the University of Chester Department of Social and Communication Studies ethics committee, whose conditions were incorporated into the design.

As it was likely that participants may have personal experience of suicide, have lost clients to suicide or may disclose breaches of ethics codes or bad practice, there was a need for informed consent, confidentiality and anonymity, and adherence to data protection procedures but also a degree of sensitivity in approaching and interviewing participants.

In interviews, participants disclosed experience of suicidal feelings, losing relatives to suicide and in one case, losing a client to suicide. When this arose, the participant was asked whether they felt ok to continue. Having explored the issue, they felt that they were and the interview continued. Most participants felt that the interviews had raised issues for them around working with suicidal clients, which they were planning to take to supervision and copies of the transcript of their interview were offered to them.

The study has involved a considerable amount of work in addition to other work and personal commitments. This has at times caused me significant amounts of stress and I have had to take a break from the study at several points. I have been fortunate in having an understanding and supportive research supervisor who has enabled me to manage the process to the best of my ability, and I have also received support and

encouragement from my counselling supervisor and various colleagues which has sustained me throughout the work.

Reflective Statement

My interest in the issue of suicide stemmed from my own experience of depression and suicidal ideation and this led me to study psychology and counselling. I was interested in exploring not just counsellors' experiences in working with suicidal clients but the dilemma around when or if the counsellor takes on a degree of responsibility for the suicidal client, and how much, especially the issue of whether to break confidentiality. It is this that has given me greatest difficulty personally, and one that gave rise to most intense and impassioned discussion with colleagues. I feel that this is an important topic to investigate, in terms of the magnitude of the professional, legal, ethical and philosophical issues, the complexity of the decision making process involved, and the potential consequences both for the life of the client and the professional and emotional state of the counsellor.

Conducting this study has taken two years and the work has had to be put on hold several times for personal and professional reasons. I have learned a great deal about working with suicidal clients from the literature and from the participants who so openly shared their experiences with me, and from my supervisor. I have also gained from having conducted the research process - especially from being able to change and adapt in response to circumstances - and in learning lessons for the future where things haven't worked as well as expected. Although the work has proved extremely challenging at times, it has been a worthwhile experience and I hope that the findings will be of use to those working with the suicidal and stimulate more research in this area.

Chapter Four: Findings

The following are the twelve 'meta categories' or 'outcome propositions' derived from an analysis of the data, along with their 'rules of inclusion' (Maykut & Morehouse, 1994). These represent a distillation of the themes to emerge out of all six participant interviews.

Table 2: Outcome Propositions/ Categories

No.	Category Name and Rules of Inclusion
1	**A respect for autonomy, and an awareness of risk but it still may not be enough...: The impact and limitations of training and experience** Counsellors found it difficult to recall their core training with respect to suicide other than giving them a respect for clients' autonomy. Post qualification experience and training was felt to have had more influence but could still be felt to be inadequate when faced with a suicidal client.
2	**Protective framework or restrictive constraint? The impact of organisational context, policy and procedure.** Counsellors have to work within the context of organisations with their own needs and priorities. These impact directly on decisions counsellors have to make around breaching confidentiality when working with suicidal clients.
3	**The Swan moment: Counsellors' thoughts and feelings when a client says they're suicidal** Counsellors experienced a distinct cognitive/ emotional split between feelings of panic, anxiety and helplessness and thoughts of what the situation demanded of them as a professional. This potentially threatened to disrupt their natural empathic connection to the client.
4	**I respect your autonomy, I just don't want you to act on it: Counsellors' perceptions of suicidal ideation in clients.** Despite believing strongly in their clients' autonomy, counsellors found it difficult to trust in, as they sometimes struggled to fully empathise with suicidal feelings even though accepting them as the client's reality. Their own personal and professional experiences can impact in this area.
5	**Assessment: Informed, dialogic and continuous.** Counsellors view assessment as a continuous, dialogic process, using their own skills and experience, sometimes informed by more formal tools**.**
6	**I'm responsible to my clients, not for them- but when they're suicidal, I find myself feeling some responsibility: Responsibility for the suicidal client: where does it and should it lie?** Counsellors believe that clients are responsible for their own lives and they, as professionals, are responsible to them. However, when the client was suicidal, counsellors found themselves feeling and sometimes taking a proportion of responsibility, which they found difficult to quantify, or evaluate in terms of therapeutic effectiveness.
7	**It feels worse when they're young… The vulnerability of young clients** Counsellors feel young people are more vulnerable and less autonomous than adults, find them more challenging to work with because of this and

	feel a greater degree of responsibility both toward and for them.
8	**Being a responsible professional** Suicidal clients can make counsellors feel inadequate as a professional, that they need to do more in order to do enough and fear the emotional and professional consequences of feeling or being seen to have done less.
9	**What I can offer to suicidal clients: space, hope and alternative options.** Counsellors feel that they can offer a safe space for clients to talk about suicidal thoughts, helping them explore options other than taking their lives and giving hope and empowerment
10	**Holding the situation within the boundaries** Counsellors can choose to continue to work with the suicidal client, sometimes contrary to organisational policy, on the grounds of their therapeutic approach and the ethical framework of their professional organisation but this feels risky to them
11	**Putting on the brakes and putting up the safety nets: Counsellors' actions when working with suicidal clients.** Counsellors channel concern for the client and their own professional anxiety into a variety of means of managing the risks to the client and also to themselves.
12	**Sharing or dissipating the burden.** Counsellors sought to dissipate the burden of responsibility they can feel in working with suicidal clients by seeking reassurance and guidance from supervisors and, where appropriate, sharing concerns with supportive superiors.

Category One: *A respect for autonomy, and an awareness of risk but it still may not be enough...: The impact and limitations of training and experience*

As none of the participants had been qualified less than three years and most for considerably longer, it wasn't surprising they mostly had vague recollections of training with respect to suicide. Most felt this had been covered, although post qualification training and years of client work was felt to have had more impact.

> *<MW: Was suicide covered in your training as an issue, as a separate sort of topic?>*
> *Erm, I think it was but it was quite a long time ago…*
> *(Participant 3, p12)*

> *…it's more the workshops that I've done since because of the level of work that I do here… I don't particularly remember, of course it did come up in our skills work, erm, but we didn't specifically focus on working with the suicidal client*
> *(Participant 1, p23)*

The one thing training had given which was particularly relevant was a strong respect for client autonomy.

> *…I think it's my person-centred training that's given me that… ability and that understanding of autonomy… I'm going back to that word again… …so the client has the right to do as they wish…*
> *(Participant 5, p23)*

One participant expressed the view that no matter how good the training, it could never adequately prepare you.

> *…I don't think anything can ever prepare you for… for working with a suicidal client, I think… nothing can take away the, the feelings that you have…*
> *(Participant 6, p9)*

Category Two: *Protective framework or restrictive constraint? The impact of organisational context, policy and procedure.*

Participants were largely working in organisations whose main purpose was not therapy, with their own needs and priorities, communicated in a number of formal and informal ways.

This category covers the impact of external frameworks on counsellors and their client work, specifically around contracting, managing risk and to some extent assessment. It is related to Category Ten, which describes situations where the counsellor decides to continue working with a suicidal client, potentially in conflict of organisational guidelines.

Organisations impact upon counsellors in three ways: directly via policy and procedure, in the relationship counsellors have with superiors and other staff, and in the culture of the organisation.

> *…there's something about I guess, something coming back on the organisation and their corporate identity I guess and they want to make sure that their guidelines are quite strictly followed…*
> *(Participant 4, p4)*

> *…it's quite hard working in an organisation like this because the main focus of this organisation is not… …it's not about therapy…*
> *(Participant 5, p8)*

How comfortable counsellors felt with their organisations was often dependent on the relationship they had with line managers and other key individuals.

> *…professionally I suppose I'm fortunate in this organisation that they respect that autonomy and that professionalism about that…*
> *(Participant 3, p2)*

Where this relationship was defined by mutual respect and co-operation, and allowed a degree of latitude within organisational policy, counsellors felt respected, understood and supported.

However, policies could conflict with the counsellor's own professional judgement and beliefs, which could cause difficulties.

> *…there's always that conflict because I, you know, I need to hang on to the ethical code… …and that sense of autonomy. At the same time… I work in an organisation that wants different things… …and is led in a different way…*
> *(Participant 5, p17-18)*

Most participants used formal, written contracts, which mentioned suicide or suicidal intent specifically, usually due to organisational guidelines but sometimes by their own choice. Producing a contract that protects the client, the counsellor and also the organisation was a difficult balance to strike:

> *… we've sort of tried to cover both er, sets really if you will, and find a contract that erm, both safeguards us and safeguards the client and meets the organisational erm… requirements… And it's always a challenge! (laughs)*
> *(Participant 1, p3)*

This raised suicide at the contracting stage, which all but one counsellor was specific about, feeling it was important to be clear and precise even when contracting verbally in a crisis.

…I think it's important when I'm contracting to use the word, to show that I'm not afraid to use the word, I'm not afraid to work with it.
(Participant 3, p9)

It was felt important, especially with young people, to make a clear distinction between self-harming and suicidal intent, for them not to be put off disclosing. One participant working in less prescriptive environments preferred a general form of words, feeling there was no need to be specific unless the issue arose with that client. Generally counsellors referred back to the contractual boundaries if suicide arose as an issue, making it clear that they were happy to explore those feelings but reminding them of the boundaries.

…just for you to be aware, don't want you to stop sharing what you want to share but just be aware that within our original contract, this is what I said…
(Participant 4, p11)

Category Three: *The Swan moment: Counsellors' thoughts and feelings when a client says they're suicidal*

…a bit like an adrenaline burst isn't it, you know- (sharp intake of breath) 'Oh no, I wish they'd not said that!'
(Participant 1, p38)

…for me, there's always a… a sinking feeling inside, 'this is going to be hard'
(Participant 2, p18)

…it's like I'm on red alert now…
(Participant 5, p27)

Two participants used the metaphor of 'the swan' to describe having to remain calm and professional on the surface whilst underneath, feeling panic, anxiety and helplessness but others talked of a similar cognitive/ emotional split.

Yes, it's the swan moment isn't it? You know, you're calm and serene on the outside and your stomach's churning up inside and… you know, you're pedalling furiously in your mind trying to think 'ok, so on a scale of nought to ten, where might this lie…
(Participant 4, p24)

I'm just thinking it's almost like the… you know the swan… kind of on the surface appearing very serene to the client… …but underneath, you know, kicking like crazy…
(Participant 6, p16)

The finality of a potential life and death situation was felt to be behind these emotions.

<MW: What is it that makes it feel different to any other issue?>
'cause it's life and death… …there is something about that loss of life… something about the finality
(Participant 1, p27-28)

There was the possibility of a cognitive/ emotional split around the contract; on a thinking level, it was clear and specific, however, counsellors felt they were betraying the client when they considered breaching confidentiality, which felt as though there could be some kind of 'emotional contract'.

I think at a head level it's very clear, at an emotional level I think it's a lot harder […] I felt I was erm… kind of betraying her in some way, letting her down, I was going against something…
(Participant 1, p31)

Anxiety could drive a proactive risk assessment and what counsellors felt they needed to do about it. They thought this through, and at the same time tried to maintain their empathic connection with the client, which could be difficult.

But the risk management brings in this little machine that starts ticking away, it's a bit like this clock, ticking at the side, as soon as you notice it… …tick tick tick, there it is… and you want to pull yourself back into empathy…
(Participant 2, p20-21)

Category Four: *I respect your autonomy, I just don't want you to act on it: Counsellors' perceptions of suicidal ideation in clients.*

Whilst unanimous in upholding client autonomy, counsellors found it difficult to empathise with suicidal feelings if they had not experienced them, even though they accepted the client's feelings or that suicidal feelings were a part of life.

I think that suicidal thoughts are quite a normal part of a human being's experience…
(Participant 2, p1)

…and although I as a counsellor and I as a human being might find that extremely difficult at times to understand why somebody might wish to do that… erm… at the end of the day it's not my life it's theirs and I haven't had their experience in life that they have…
(Participant 4, p18)

I think because taking my own life would never feel the right decision… I think I would find it quite hard if someone I was working with took their own life… to fully accept that that was the right decision for them
(Participant 1, p22)

As we do not and cannot rely on having had similar experiences in order to empathise, this raises the question as to whether suicidal feelings could be a special case. The counsellor's personal and professional experiences could impact here:

I understand why people commit suicide, I understand, I've had my own suicidal thoughts in my own life…
(Participant 2, p10)

I've had a family member that killed herself, I was quite young at the time but I guess you know, that's probably had some impact on how I see it and how I deal with suicide… […] … I certainly wouldn't convey it but I can't sort of say that it's not around…
(Participant 3, p10-11)

Some participants raised the issue of whether suicide could be rational, especially where it appeared to be an impulsive response to a crisis or temporary overwhelming pressure and there could be difficulty in trusting the client in this regard.

…that actually, to trust that you know, if they take their own life, that was the right decision for them… it feels as though it would be quite difficult to be with
(Participant 1, p22)

At least one participant felt the fact the client was speaking openly about suicide meant they wanted to be helped.

…they have the choice about what they tell you and I think that's why they tell you quite often because they actually want, they want to help themselves through being helped…
(Participant 2, p24)

Category Five: *Assessment: Informed, dialogic and continuous.*

Although some participants used or would consider using tools to inform assessment, none relied on them completely, nor would they.

> *…I'm not using any paper-based system and I'm quite pleased that I don't have to do that…*
> *(Participant 3, p4)*

> *…so we do not use CORE as a risk assessment tool but if it's on CORE then we'll make sure that we address it. So what we use as risk assessment is dialogue… er, the CORE informs the dialogue…*
> *(Participant 2, p3)*

In contrast, where information about the client was already available from referral or assessment, counsellors often preferred not to use it.

> *…I like a sort of blank canvas and not having my… the way in which I might work with this- tainted for want of a better word- by someone else's perception of that person, so then I've nothing to judge them on 'cause they just come to me fresh as it were…*
> *(Participant 4, p11)*

Counsellors described assessment as a continuous and dialogic process, especially in the first session.

> *…when the session starts, then I guess I am assessing all the time…*
> *(Participant 1, p8)*

They felt confident doing this, that it was integral to how they worked, and often had experiential knowledge of risk factors.

> *<MW: So you would, certain things would flag it up for you?>*
> *Erm… yeah, I think things like helplessness, hopelessness… Things like social support, lack of, you know, isolation…*
> *(Participant 6, p5)*

Category Six: *I'm responsible to my clients, not for them- but when they're suicidal, I find myself feeling some responsibility: Responsibility for the suicidal client: where does it and should it lie?*

Counsellors can feel and even sometimes take responsibility for suicidal clients, despite believing clients are responsible for themselves, and they as professionals are responsible to them.

> *…it feels like I'm probably the main key person that may be keeping that person going and keeping them alive*
> *<MW: Mm, that feels like that could be quite a burden almost…[…]>*
> *It's a weight, yeah, you could use bur- it's a weight, a responsibility…*
> *(Participant 3, p23)*

> *…on a head level I'd like to think I've got my head round it's their responsibility (smiling) … On a human emotional level… I think with certain maybe clients, certain times of year like that… erm… I can have… I feel that responsibility…*
> *(Participant 3, p28)*

The above quote again shows the cognitive/ emotional split.

> *…I don't feel responsible for clients because ultimately they're responsible for themselves but it's interesting having just talked about suicidal clients that I feel much more responsible for them…*
> *(Participant 6, p21)*

> *<MW: …does it feel like this is something you're taking [responsibility] or something that the client is giving you? …Or is it both?>*
> *Probably I would say I think the client's giving and I'm willing to take…*
> *(Participant 6, p22)*

It felt impossible to quantify the responsibility felt or to what degree it was effective.

> *Not all [responsibility], but I would say… I would say certainly some… I would find it hard to quantify really…*
> *(Participant 6, p22)*

> *I guess you know, the fact that she did what she did I guess that extra mile was, you know, never going to be long enough… […] …she'd find some other ways and means of doing what she wanted to do…*
> *(Participant 4, p40)*

Here it depends on whether effectiveness is seen as synonymous with prevention - although counsellors could accept that the logical consequence of facilitating client autonomy could be suicide, they felt their role was to help find alternative options.

Category Seven: *It feels worse when they're young… The vulnerability of young clients*

Five out of six participants felt young people were less autonomous and more vulnerable than adults, being less developed and having less support. Counsellors found them more challenging to work with and that they needed to take on greater responsibility toward and for them.

> *I guess I feel that responsibility… […] …and possibly I take that responsibility as well, erm, I know that I work… harder in that counselling relationship because of the age of that client than I used to perhaps on placement or with adults*
> *(Participant 1, p39)*

> *…it can feel slightly different when you're working with somebody who's very young who's suicidal… […] …they're developing who they are and an adult might have more of a sense of who they were to make that decision…*
> *(Participant 3, p11-12)*

> *…for those maybe that have just come from school and they've been used to being looked after… […] …well is this person actually fully responsible for themselves…*
> *(Participant 5, p41)*

This data largely came from questioning participants about their motivation for participating. The majority work in the education sector primarily, mostly with 16 – 19 year olds and it was working with suicidal young people that had motivated several.

Category Eight: *Being a responsible professional*

Whilst acknowledging clients are responsible for their own lives, suicidal clients can make counsellors feel they need to do more, question whether they've done enough and worry about the emotional and professional consequences of client suicide.

> *Have I done enough? That's the helplessness. Have I done enough to offer that support?*
> *(Participant 1, p20)*

<MW: […] What are you feeling, thinking about yourself as a counsellor when that client's saying they're suicidal?>
…am I… professional enough, am I competent enough, am I enough…
(Participant 6, p13)

Counsellors felt client suicide would be perceived a failure by their organisation but even possibly themselves.

…a number of people have said to me 'the counselling service has never had a suicide', and that feels a pressure in itself…
(Participant 1, p41)

I don't know whether there would be that same understanding and support for us as counsellors. D'you know what I mean? It would be, it would presume more of our failing, or why has that happened rather than a supportive atmosphere…
(Participant 1, p42)

The possibility of vicarious trauma was raised along with the need for self-care.

…'cause I don't want to feel everything, I don't want to be traumatised by what I'm being exposed to…
(Participant 3, p14)

…I've had to learn to… to some degree to detach… from it, 'cause if I took it all on board I wouldn't be able to do the job I did
(Participant 3, p21)

The compulsion to do more could cause counsellors to stretch professional boundaries to protect the client.

I'd have done anything to be able to say 'you can come to mine for Christmas'…
(Participant 3, p28)

…I made a judgement that I had an extra long session with her, it was about an extra fifteen minutes and I was so not unsure that she was actually going to get the bus to go home […] and I made a judgement call and I'm still not sure if it's the right one that I offered her and did take her home…
(Participant 4, p38)

Included in this category are counsellors' reflections on their own candour and their hopes others would be similarly honest.

I just sometimes wonder whether other counsellors would be as open about how vulnerable they feel sometimes…
(Participant 2, p33)

Category Nine: *What I can offer to suicidal clients: space, hope and alternative options.*

Counsellors almost universally felt they offered a safe space for clients to discuss suicide with the hope of exploring other options and giving hope and empowerment.

...that therapeutic hour that we have together with a client might be the only space in which they're able to be open and honest with themselves to be able to explore those thoughts… […] …because other people… don't want to know…
(Participant 4, p22)

…if they're saying they're suicidal and they're going to do stuff then that's… that's stuff you can work with in the room with them…
(Participant 5, p20))

I think it's about accepting where they are now… but with the hope of… […] …things changing in the future
(Participant 6, p18-19)

Category Ten: *Holding the situation within the boundaries*

This relates to Category Two and is perhaps its counterpart. Counsellors may, on the basis of professional judgement, continue to work with suicidal clients, even contrary to organisational policy. This feels risky, as responsibility lies with them and not the organisation, although in the example below, the principle became enshrined in policy.

And it's me, perhaps taking that risk of holding that space, holding that student, trusting them in that…
(Participant 1, p26)

I guess in some ways I still follow my own judgement… […] …at the end of the day… nobody knows the client better than I do… …and I guess it's going to be my judgement as to… having known them over X number of sessions, whether it is truly their intention to do what they say they're going to do or whether it's not…

(Participant 4, p5)

…I fought and fought and eventually it went through to the governing board that we could put that in that the counselling service was the only place where we could talk about suicide and child protection issues and it not necessarily go to the safeguarding officer…
(Participant 5, p7)

Category Eleven: *Putting on the brakes and putting up the safety nets: Counsellors' actions when working with suicidal clients.*

Several participants mentioned slowing things down, putting the brakes on, trying to contain the situation and manage risk, to give the client time and space to explore their situation, including the potential impact of suicide on others, and consider alternative options.

So being able to slow it down for them also helps with my anxiety to kind of slow things down.
(Participant 1, p25)

…it's almost as if I have to kind of help them put the brakes on to give them time to maybe obtain a different perspective on things…
(Participant 6, p13)

One participant referred to Andrew Reeves' term 'safety nets' meaning helping the client put supports in place.

I'll explain to them how sometimes certain things can actually lead them to be more at risk… […] …so you know, I talk about how they can keep themselves safe as well, whilst they make a decision.
(Participant 2, p15)

This felt driven by the counsellor's need to protect the client and also themselves:

…I'm more aware that I need to be professional and cover my back, but I wouldn't be putting that onto the client…
(Participant 3, p27)

Category Twelve: *Sharing or dissipating the burden.*

This follows from feelings of responsibility counsellors can have for suicidal clients and relates to the need to dissipate or share that burden. The actions in Category Eleven also serve this purpose but are mostly confined within the session. Responsibility might be 'passed back' to the client at the end of the session:

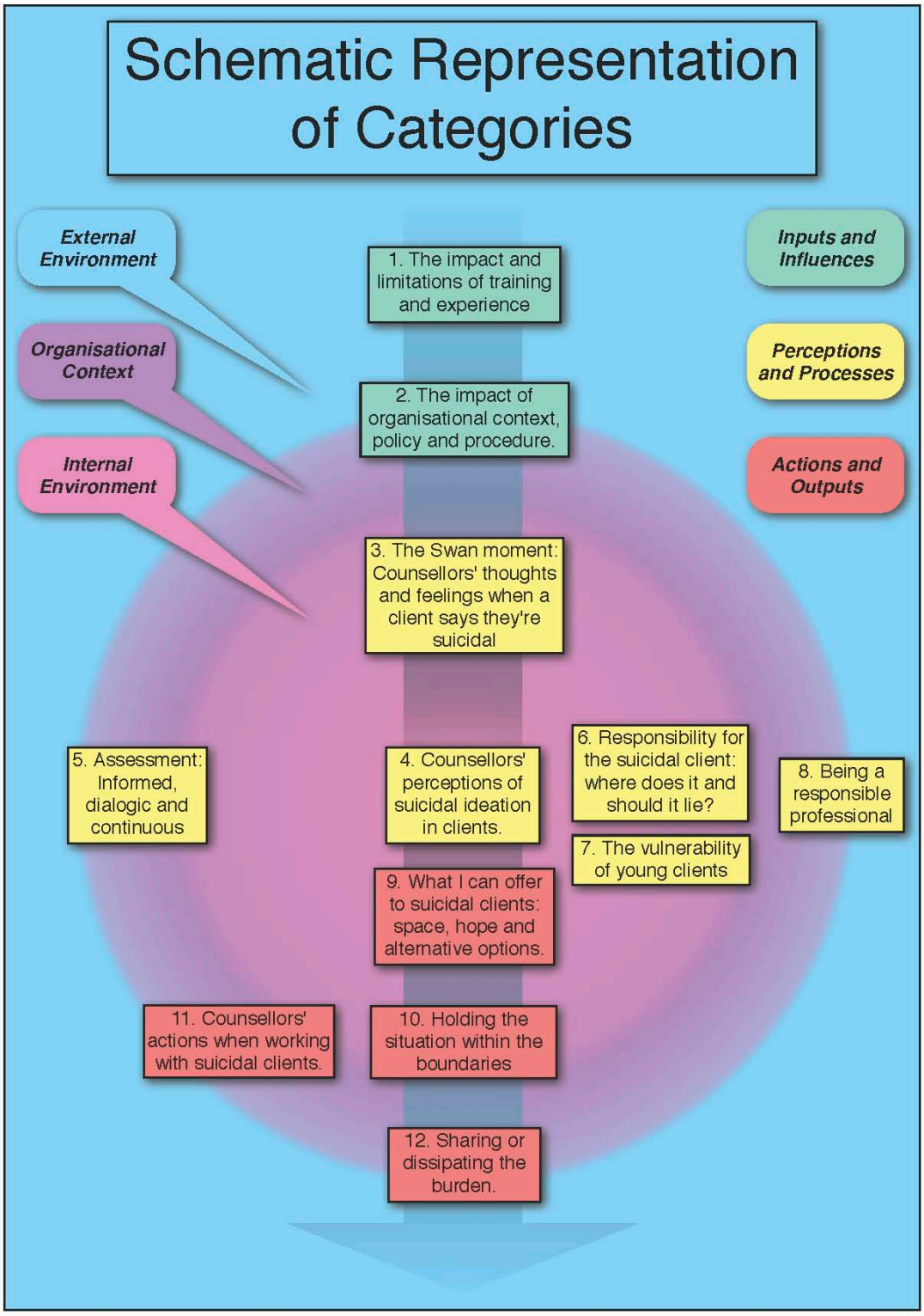
> *…that stuff belongs to them it doesn't belong to me… […] …my summing up of bringing this session to a close would be giving back what they shared with me…*
> *(Participant 4, p33)*

Beyond the session, counsellors seek reassurance and guidance from supervisors and, where appropriate, share concerns with supportive superiors.

> *…my first port of call would be my supervisors… […] …and I know I would get some good support from them, erm… and if I was, you know, er… unsure as to how to progress then I would seek their support being more knowledgeable in that area…*
> *(Participant 4, p4)*

> *'Have I done everything'… yeah, 'was I enough for this client'… yeah, so I'd definitely say it's a kind of offload and a, and a reassure… you know try and get that reassurance…*
> *(Participant 6, p19)*

Figure 1: Schematic Representation of Categories



Chapter Five: Discussion

This study's purpose was to revisit that of Reeves and Mintz (2001), after the elapse of ten years, to see how much, in the authors' words "the maturity and accountability of counselling…" has continued to develop "…through a process of evolution" and to examine the issue of responsibility which emerged from the literature. To what extent, therefore, do the findings of this study coincide with those of Reeves and Mintz and where might they fit with the literature?

In Figure 1, the Schematic Representation of Categories, the twelve categories are positioned relative to each other, giving a sense of the relationships between them and how they might fit together. This is presented within a qualitative paradigm as one possible representation of the phenomena studied. Three concentric domains are posited: the External Environment of government, organisations, training institutions and society, the Internal Environment of the counsellor's thoughts, feelings and perceptions, and in-between, the Organisational Context within which they work, its policies, procedures and structure.

The twelve categories divided into three groups: Inputs and Influences, Perceptions and Processes, and Actions and Outputs, the arrow indicating a sequential flow while acknowledging the inevitability of external inputs and feedback loops. These groups loosely correspond to Reeves' category groupings from the dissertation research upon which Reeves and Mintz (2001) is based: Impact of the Organisation, The Counsellor's Phenomenology, and Impact on Practice (Reeves, 1997).

Inputs and Influences

Category One found counsellors recalled little core training around suicide, save giving them a respect for autonomy, and relied mostly on post-qualification training and experience. This largely coincides with Reeves and Mintz' Category Nine 'Counsellors do not feel their training has enabled them to work effectively with suicidal clients- both in terms of skills development and theoretical knowledge', and with Reeves (2010; 2004) assessment of current counsellor training. Some diploma courses trainers did not believe students were competent to work with suicidal clients

upon completion and Reeves cites Dryden and Thorne as stating a diploma qualification is a basic level requiring further training beyond. His conclusions that 'Competence in this area is usually achieved through gaining day-to-day experience of working with clients, and processing that work in supervision,' (Reeves, 2010, p. 54) were borne out by the majority of this study's participants. However, Participant 3, when giving feedback in Member Checking, stated they did not feel inadequate when dealing with suicidal clients, and whilst this theme emerged strongly from the data, it is not necessarily universal.

So, little has changed in this regard with the elapse of a decade. Winter et al (2009) concluded lack of training and support was the main barrier to successful therapy with suicidal clients, tentatively suggesting appropriate training was sufficient for effective intervention and that experience might positively correlate with effectiveness; a finding corroborated by Neimeyer (2001). McAdams and Foster (2000, p. 107) go further, recommending that 'Specific training in client suicide should be a routine component of the counselor educational process'. However, Carney and Hazler point out that:

> *Even if mental health counselor training could be extended by years, the needs of all the populations we must treat would not be addressed. It is, therefore, incumbent on counselors to take personal responsibility for increasing their competencies with high-risk populations through continuing education.*
> *(Carney & Hazler, 1998, p. 29)*

Category Two, that organisations impact directly on decisions counsellors make around breaching confidentiality is a direct correlate of Categories Two and Three in the Reeves and Mintz (2001) study: 'Organisations influence counsellors' decisions about when and how to break confidentiality when working with suicidal clients' and 'The organisations that counsellors work for expect interventions with suicidal clients which are often in conflict with the preferred personal choices of the counsellors themselves'. Little appears to have changed here also, perhaps not surprising given organisations are obliged to comply with the policy agenda set by government:

> *The task defined by UK and international mental health policy is for all mental health workers to recognise and assess suicide risk and to intervene and prevent suicide...*
> *(Reeves, 2010, p. 51)*

It seems this is an aspect of counselling unlikely to change without a radical policy shift and that will continue to 'cause dissonance for those practitioners who view suicide in philosophically different ways, and who personally do not subscribe to the notion of prevention,' (Reeves, 2010, p. 51). However, this study demonstrates successful compromises can be negotiated if there is communication and co-operation between counsellors and management.

There is considerable contradiction between this Category and three other Reeves and Mintz categories corresponding to it, specifically around contracting. Reeves and Mintz counsellors avoided formal contracts, allowed clients to set boundaries regarding what was discussed and did not specifically discuss issues around suicide. Counsellors in this study almost all used written contracts, specifically named suicide and made the distinction between it and self harm, and revisited the contract if the situation required. Whilst this may suggest a shift to more formal and explicit contracting, it could be that the overwhelming majority of the counsellors in this study work within the education sector, half of them with 16-19 year olds. This has an impact on the policy environment and risk management of these organisations and on the counsellors themselves, as evidenced by Category Seven. One counsellor working in less prescriptive environments preferred a more general form of words when explaining breaches of confidentiality. This is the only area of agreement with Reeves and Mintz' Category Four 'Counsellors encourage suicidal clients to set their own boundaries regarding what issues are discussed, so as to prevent further distress'.

Perceptions and Processes

Category Three reinforces Reeves and Mintz' Category Thirteen, 'Counsellors experience a range of distressing feelings when working with suicidal clients including, anxiety, fear, panic, impotence and doubts about their ability to practice'. 'The Swan' metaphor captures the split between counsellors' thoughts and feelings and the professional role they are maintaining in action and appearance. The demands of the situation start a cognitive process which one participant likened to a machine, which can disrupt the empathic connection with the client. Reeves (2010) cites Leenaars as suggesting that feelings aroused in the counsellor by the suicidal

client can cause such a disconnection, as does Rubenstein (2003), however, these are unacknowledged feelings of negative counter-transference and not necessarily the same as those of this study's counsellors. From a person-centred perspective, anything disrupting the empathic connection with the client might negatively affect the therapeutic alliance. If this is necessary to assessing and managing suicidal risk, it may be beneficial, however, this emphasises the importance of exploring any negative feelings aroused by the client thoroughly in supervision.

Reeves (2010) suggests negative feelings are a normal and necessary part of working with suicidal clients, providing a 'viscerally important psychological connection' (Reeves, 2010, p. 143) and 'an understanding of risk unattainable by 'tools''. He questions whether counsellors claiming not to feel distress in these situations are sufficiently present in their work. Although this theme emerged quite strongly from the data, Participant 3 in their Member Check feedback stated categorically that they did not feel panic or anxiety working with suicidal clients, so this is not a universal experience in this study.

There was support for Reeves and Mintz' Category Sixteen, 'Counsellors feel they are letting down and betraying clients when they break confidentiality because they perceive the situation is then handled insensitively', again represented by a cognitive/ emotional split:

> *I think at a head level it's very clear, at an emotional level I think it's a lot harder […] I felt I was erm… kind of betraying her in some way, letting her down, I was going against something…*
> *(Participant 1, p31)*

The implication is that cognition and emotion are at odds. At a thinking level the counsellor knows they must breach confidentiality; on an emotional level, this feels like a betrayal. It seems there could exist an 'emotional contract' with the client with different rules to the formal one. Possibly this relates to the counsellor's beliefs around client autonomy as found by Reeves and Mintz (2001) and Reeves, Wheeler, et al. (2004) and is an area where this might cause difficulty.

Category Four directly correlates with Reeves and Mintz' Category Ten, 'Counsellors' own views and beliefs about suicide will influence their responses to suicidal clients'

and reaffirms the literature, including Winter et al.'s (2009) conclusion that this should form part of suicide intervention training:

> *A counsellor's views on suicide, influenced by their personal or family history, spiritual or religious views, experience of supporting family or friends… will have great significance in how they subsequently respond to suicidal clients…*
> *(Reeves, 2010, p. 127)*

The findings of this study, that counsellors respected clients' right to end their lives but did not want them to do it is an exact correlate of Hammond and Deluty, cited by Werth and Liddle (1994) and also of Lussier, who describes this as 'suicide as an option (but not for my client)' (2005, p. 4294) and explores this with Cognitive Dissonance theory. It appears there are different beliefs operating and dissonance between them.

Most intriguing was the finding that counsellors who had not felt suicidal struggled to empathise with suicidal clients. This is surprising as it would be impossible for a counsellor to rely on having similar experiences to clients in order to empathise, but it may be that suicidal ideation is such an extreme experience that it is difficult or impossible to empathise with. Widiger and Rinaldi (1983, p. 263) state that 'acceptance of suicide entails an empathic understanding of the patient's tragic condition and a recognition of an inability to relieve the suffering', implying that empathic understanding, the acceptance of suicide as an option for that client and the feeling the counsellor was powerless to help – as with Reeves and Mintz' (2001) participants - were inextricably linked. If the counsellor is unaccepting of suicide, which Neimeyer et al. (2001) found positively correlated with intervention competence, it would seem they cannot feel both an empathic connection to the client's suicidal feelings, and unable to relieve their suffering. This raises the possibility that empathy with suicidal feelings could negatively correlate with intervention competence as defined in by Neimeyer et al, if coupled with a sense of powerlessness to alleviate them.

Category Five partially agrees with Reeves and Mintz' Category Eight, 'Counsellors see risk assessment as an informal rather than formal process'. Although some participants in this study make use of or would use formal tools to inform assessment, none relied on them, nor would they; something they have in common

with those from the original study, who highlighted a 'lack of confidence in appropriate risk assessment approaches as significant causes for concern' (Reeves & Mintz, 2001, p. 172). However, the process described in this study, although informal, was proactive, informed by knowledge of risk factors and is best termed 'dialogic' (Reeves, 2010, p. 12).

This study's counsellors appear more aware of the necessity of risk assessment and engage more proactively in it than Reeves and Mintz counterparts, which could indicate this has developed over the past decade, or, again, might reflect the participants' work contexts. Both samples have similar experience levels, all Reeves and Mintz' counsellors having at least six years' since qualification, whereas only one from this study was less (Participant 1, 3-5yrs) and a number considerably more. Therapeutic approach could be a factor, as all Reeves and Mintz's counsellors were person-centred, whereas in this study, two thirds were integrative with one third person-centred. However, organisational context still feels the major difference between them as Reeves and Mintz were able to sample purposively and select a sample representative of different working environments, whereas, in this study, the sample is more a 'self-selected extreme cases' one focusing almost exclusively on the further and higher education sector, where it would appear there is more emphasis on assessing risk.

Overall, this emphasises the necessity of training around suicide risk. Without this, counsellors are not equipped with the skills, or the imperative to assess, despite working within policy frameworks implicitly requiring them to. However, we should note the danger of becoming so preoccupied with risk that actions become '…focused solely on risk assessment rather than therapeutic change' (Sharry et al., 2002, p. 383).

Category Six has no parallel in the Reeves and Mintz study as it emerged from the literature. Counsellors found they took on a degree of responsibility for suicidal clients, despite believing overall they were responsible *to* their clients, not *for* them, and this appeared a cognitive/ emotional split. It was difficult to quantify how much responsibility they took and whether it facilitated therapy. Bond (2010) in proposing an ethical decision making model, suggests ascertaining whose dilemma it is, starting from the position that the counsellor is responsible for methods used, with

the client responsible for the outcome. However, he acknowledges counsellors may feel they hold more responsibility for clients who self harm, are young, or lack capacity to make rational judgements.

By assessing risk, counsellors take on a degree of responsibility for managing it, not only to the client but also to themselves and their organisation. To what extent this constitutes responsibility for rather than to the client is a moot point, as is the degree it aids the therapeutic process. The literature gives confusing messages here, for whilst there is emphasis on the importance of training in recognising and managing risk, there are a number of studies which question the effectiveness of taking responsibility for suicidal clients.

> *All the precautions and all the management may result in encouraging one of the most lethal aspects of the suicidal individual, that is, his tendency to make someone else responsible for his staying alive.*
> *(Hendin, 1981, p. 469)*

One participant (Participant 6, p22) suggested this kind of exchange was taking place; that the client was giving responsibility and they were prepared to take it. Trimble et al. (2000) concluded successful coping with suicidal clients was the realisation of client responsibility, whilst Cummings et al. (1996) regard taking responsibility as one of four 'outmoded attitudes' leading to the mismanagement of suicidal patients, and Olin (1976) declares taking responsibility a 'therapeutic disaster'. Richards (2000) found therapists needed to realise the limits of their powers and that despite their best efforts, clients may take their own lives. Interestingly, clients undergoing DBT cited by Winter et al (2009) felt taking responsibility was an important component of therapy.

It seems from categories two and eight, that as Reeves (2010) postulates, there is a downward transmission of societal discomfort about death, loss, grief and suicide via policy makers and organisations to the individual, 'Ultimately that is where responsibility seems to be located; no-one wants to be holding the parcel when the music stops.' (Reeves, 2010, p. 52). Responsibility for the suicidal may be given to the counsellor by society via institutions and by clients themselves. Counsellors then find themselves taking on an unquantifiable proportion of this, possibly contrary to

their beliefs and training, and as a number of studies suggest, with doubtful effectiveness.

This study has been exploratory, and as such, it perhaps raises more questions than it can answer, however, taken with the literature, responsibility seem to be the theme linking the others together.

If suicidal clients incline counsellors to take responsibility for them, Category Seven indicates young suicidal clients do so even more. Young people were felt less autonomous than adults, to have less decision-making capacity and be more in need of support. The literature would, again, sound a note of caution here:

> *A therapist's own inclination to see himself as the saviour or rescuer of the suicidal patient can be responsible for perpetuating suicidal behaviour, particularly in young people… suicidal young people arouse rescue fantasies in therapists*
> *Hendin (1981, pp. 472-473)*

Whilst we cannot say how taking a greater degree of responsibility and working harder manifests itself in practice, the literature sheds light on what suicidal and self-harming young people find helpful. Storey et al (2005) found young people resented therapists with their own priorities and agenda and generally Winter et al (2009) found that a strong therapeutic relationship based upon respect, understanding and acceptance was preferred to one concentrating upon theory or self-injurious behaviour. As stated, this category is likely to reflect the self-selected nature of the sample, the majority of which work with young people, although it does highlight further the issue of responsibility. In the Member Checks, one participant stated that they had made no comments concerning young people but that their experience tallied with the findings.

Category Eight highlights responsibilities felt by counsellors as part of their role. Suicidal clients made them feel they needed to do more, worry about doing enough and fear the consequences should a client take their life. This relates to Reeves and Mintz' (2001) Category Fourteen 'When working with suicidal clients, counsellors doubt their own professional competence and their ability to work safely and appropriately', and Category Twelve, 'Counsellors feel that the threat of litigation and accusations of malpractice impacts upon their decision to intervene with suicidal

clients'. Again, responsibility is loaded onto the counsellor by society via its lawmakers and organisations, which have to work within those laws.

There is a clear expectation of counsellors in terms of actions and outcomes with suicidal clients. As Reeves (2010) says, this may cause dissonance for those with personal views not coinciding with prevention. Furthermore:

> *How counsellors respond to their most vulnerable clients is one of the ways by which other professions and society as a whole make judgements about the integrity of the profession.*
> *(Reeves, 2010, p. 57)*

Participants felt client suicide would be viewed as a failure by their organisation and even in some cases, themselves, echoing Richards (2000) and Wildman (1995). This fear might, as Reeves and Mintz (2001) participants felt, impact upon counsellors' decisions to intervene and become an obstacle (Hendin et al., 2006), or, in fact, as found in this study, a pressure to stretch professional boundaries to prevent harm to clients.

One participant (3) described how they felt they needed to emotionally detach to work with suicidal clients so as not to be traumatised and incapacitated by the client's material, and indeed, this participant noted in their Member Check feedback that they did not experience feelings of professional inadequacy. A delicate balance needs to be struck between feeling enough of a client's pain to maintain an empathic connection, whilst retaining a degree of detachment sufficient to protect oneself.

Also in this category were comments from two participants indicating they had been honest in sharing their true feelings and hoping other counsellors would do the same, whilst having doubts about this. It could be there is a discrepancy between the way counsellors present themselves as professionals and the way in which they think and feel, which would echo 'The Swan' from Category Four and also the examples of cognitive and emotional splitting in this study.

Actions and Outputs

Category Nine, refers to what counsellors feel they offer suicidal clients and it is clear that despite practical and emotional difficulties, counsellors feel they have something valuable to offer, possibly unique; a position Reeves (2010) argues strongly:

> *…counselling is ultimately about giving voice to the client so that they can begin to make change… …paradoxically we are helping clients to use the awareness of their suicidal potential to begin to move away from it.*
> *(Reeves, 2010, p. 11)*

This is backed by Winter et al (2009) who found that clients found respect, acceptance and an understanding, empathic and non-judgmental attitude to be of most help. There isn't a direct correlate in Reeves and Mintz (2001), however, Category Eleven, 'Counsellors' empathic responses to suicidal clients are aimed at trying to make contact with what they perceive to be the client's isolation' does echo one of this study's participants statement that the therapeutic hour was the only time clients get to talk about suicidal feelings as '…other people… don't want to know' (Participant 4, p22). However, accepting and exploring suicidal feelings with clients can be risky for counsellors as this may run contrary to organisational policy.

Category Ten is the counterpart to Category Two, and describes how counsellors may choose to continue to work with suicidal clients against organisational policy. Reeves states:

> *…organizations never really 'know' of these decisions, because risk is ultimately safely contained within the relationship… The risk for counsellors is of client suicide, when suddenly it transpires that the counsellor has been working outside of the organizational policy….*
> *(Reeves, 2010, p. 77)*

This echoes Category Six, with the counsellor taking on a degree of risk and responsibility, especially if organisational policy is black and white around actions to be taken. However, as Hendin states:

> *…therapy requires that the therapist be able to accept and live with some risk. As Schwartz, Flinn and Slawson point out "the only method of reducing the long term risk of suicide may be one that risks its short term commission."*
> *(Hendin, 1981, p. 479)*

The question arises, how helpful is it to have strict policies protecting organisations if this pressures counsellors into flouting them and taking on increased risk and responsibility that could be counterproductive to therapy? As Reeves says:

> *If counsellors can feel supported and contained by procedure, they are much more likely to be able to engage with suicidal clients in such a way that both will feel cared for.*
> *(Reeves, 2010, p. 88)*

This category and Category Two correspond to Reeves and Mintz (2001) Categories Two, 'Organisations influence counsellor's decisions about when and how to break confidentiality when working with suicidal clients' and Three, 'The organisations that counsellors work for expect interventions with suicidal clients which are often in conflict with the preferred personal choices of the counsellors themselves'. This appears something else unchanged in ten years, as organisations followed government prevention policy. However, there remains the potential for compromise in the setting of policy and the nature of working relationships which could, as Reeves suggests, mean counsellors feel sufficiently supported to take on the short term risk Hendin believes necessary to negate the longer term one.

Category Eleven can be seen as an extension of Category Nine as it describes how counsellors try to work with suicidal clients. However, the focus here is more the short-term management of risk to the client and also the counsellor. Strategies are to slow things down to allow the client to explore feelings and options, sensitively making them aware of the possible consequences of taking their life and putting other forms of support in place whilst this is on-going.

The nearest correlate in Reeves and Mintz (2001) would be Category Twelve, 'Counsellors feel that the threat of litigation and accusations of mal-practice impacts upon their decisions to intervene with suicidal clients'. In other words, counsellors' actions may be driven by fear of the consequences of client suicide. Bernstein puts it starkly, '…we do not want them to die because of the effect their death will have on

us,' (2001, p. 257). Winter et al (2009) in citing Davidson et al (2007) suggest therapists feel they need to work harder with clients who appear not to be improving, possibly to alleviate guilt. There is a danger, as Hendin points out of '…ineffective or coercive actions resulting from the therapist's anxieties…' (Hendin et al., 2006, p. 67), whilst both Ellis (2004) and Hendin (1981) point out that reducing therapy to management and control, in contrast to developing self-efficacy, can compromise the therapeutic alliance. However, Winter et al (2009) found increased support facilitated therapy, gave clients increased hope, which positively correlated with reduced suicide potential (Barbe et al., 2004; Dahlsgaard et al., 1998). Overall, although there are dangers in 'over-managing' a client, the strategies described here, part motivated by concern for the consequences for the therapist seem practical and respectful, despite only general backing for 'support' in the literature.

Reeves and Mintz (2001) counsellors, whilst being aware of the possible consequences of client suicide, appear not to have specific strategies for helping the client manage suicidal risk. It could be this is an aspect of practice that has developed over the last decade, or it could reflect the sample in this study almost exclusively working with young people in the education sector.

Category Twelve relates to the sense of the responsibility felt working with suicidal clients and ways counsellors seek to share or dissipate this. It might be a companion to Category Eleven as it addresses support strategies, albeit for the counsellor. Reeves' (2010) image of responsibility for the suicidal individual being passed down feels an apt one and we also have the possibility, discussed under Category Six, of the suicidal client attempting to pass responsibility to the counsellor and the counsellor maybe taking on a proportion. This might be dealt with by passing it back to the client at the end of the session as Participant 4 described, however, the main way counsellors avoid being left holding Reeves' metaphorical parcel is by taking it to supervision to unwrap, share and defuse.

Counterparts in Reeves and Mintz (2001) are firstly Category Seven 'Counsellors want their supervisors to empathise with them, to reaffirm their practice and interventions, and to reaffirm the counsellor's sense of professional competence'. One counsellor in the present study (6) used supervision for reassurance this way, which can be seen as attempting to answer questions in Category Eight 'Being a

Responsible Professional', where counsellors queried whether they had done enough. However, in Reeves and Mintz (2001) Category Fifteen 'When a client has expressed suicidal thought or intent during a s session, counsellors have informal strategies for coping afterwards which are aimed at 'distancing' themselves emotionally from the session', one gets a sense of counsellors being isolated immediately after seeing suicidal clients and coping with feelings raised largely alone to maintain confidentiality. These experiences do not relate directly to supervision, but rather to the period *before* supervision takes place and the counsellor is perhaps still 'holding' Reeves' parcel. We can see an echo in this study in Participant 3's comments in Category Eight, where they talk about not wanting to feel everything and learning to detach to avoid vicarious traumatisation.

Limitations

Though the self-selected extreme cases sample highlighted issues of responsibility especially regarding young people, it may lack representativeness and generalizability through concentrating on one client group and context. Also, the focus on responsibility, whilst providing exploratory insight has given no definitive answers and will need further investigation. Finally, the study has generated more material than was possible to include in a Masters dissertation and it is hoped that this can be put to use in other forms.

Implications for Practice

This study has backed the literature in finding a need to address working with suicide as part of basic counselling training, especially incorporating counsellors' own attitudes and beliefs. However, this would not prevent individual counsellors from giving consideration to the issue and seeking further training where necessary. They might also reflect on the amount of responsibility they feel and take for suicidal clients and assess its effectiveness. Organisations and managers of counsellors should reflect carefully that policy, implementation and working relationships, not only protect the organisation but also support practitioners to enable them to better support suicidal clients. The study also emphasises the need for self-care and good

supervision when working with suicidal clients and supervisors might wish to reassess their monitoring and support of supervisees in this area.

Future Research

Given the lack of research in this area and the specific focus of this study's sample, it would be useful to do comparison studies using other theoretical orientations, client groups and organisational contexts to ascertain any differences and similarities. For example, the study might be repeated using Samaritan volunteers of comparable age and experience instead of counsellors. This could highlight areas where differing training, ethical and legal boundaries and contact methods affect the internal processes involved.

Another issue worth further investigation would be why counsellors who had not been suicidal had difficulty in empathising with clients who were, whether this constitutes a special case of empathy failure and what the implications might be for therapeutic effectiveness.

However, it is the issue of locus of responsibility initially explored in this study which most demands further investigation as it is of central importance not only to the emotional impact of working with suicidal clients on counsellors but the effectiveness of therapy itself. This would need to take into account national and organisational policy, training, counsellors' personal attitudes and beliefs and how these translate into practice.

Chapter Six: Conclusion

This study has reaffirmed much in the existing literature, highlighted important areas for further investigation and the author hopes it may make a small contribution to the pool of knowledge in this most vital of areas. It is not just of relevance to counselors, for as Reeves says, '…almost all of the factors that I discuss and explore about working with suicidal clients can be applied to most settings and helping professionals' (Reeves, 2010, p. xii). Anything that better enables those helping professionals in working with the suicidal can only be of benefit to all.

> *Since each of us is unique, we must come to terms with our own demons, our own fears, and the terms under which we can live out our days. It is always advantageous to be armed with as much information about ourselves as it is reasonably possible to acquire. On the topic of suicide, knowledge is powerfully preventive.*
> *(Shneidman, 1996, p. 156)*

Shneidman applies this not just to therapists and clients but to everyone, as he puts it, 'Suicide prevention can be everybody's business' (Shneidman, 1996, p. viii)

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Appendix I: Search Strategy

Electronic Database Search

To give the most comprehensive search, I used both free text and thesaurus terms, in line with Winter, Bradshaw, Bunn, & Wellsted (2009). I first decided to use a broad search of the PsycINFO database, just on counselling, psychotherapy and suicide covering journal articles in English published in the last ten years since around the time of the Reeves and Mintz article (2000 - 2010) using the following search string with truncations on the Abstract field:

suicid* and (couns* or psychotherap*)

I kept 30 of the 485 hits and then used a more specific search string with the same criteria but without the date restriction:

(couns* or psychotherap*) and suicid* and (experience* or attitude* or belief* or train*)

This returned 361 hits, out of which I kept 7 not been found by the previous search.

I next conducted a Thesaurus search of PsycINFO, using subject terms decided by the particular database to produce a more accurate and relevant search. The string was:

(DE "Counselor Attitudes" or DE "Counselor Characteristics" or DE "Counselor Education" or DE "Therapist Attitudes" or DE "Therapist Characteristics" or DE "Psychotherapist Attitudes" or DE "Psychotherapeutic Processes") and (DE "Suicidal Ideation" or DE "Suicide" or DE "Suicide Prevention")

This returned 131 hits, of which I kept 23. Oddly, the Reeves and Mintz study was not found by this search, despite its obvious salience, so I ran a search using just the specific thesaurus subject terms from that article but only the Reeves and Mintz article was returned.

I then did a further thesaurus search for studies related to suicide and confidentiality. The search string was:

(DE "Privileged Communication") and (DE "Suicide" or DE "Suicidal Ideation" or DE "Attempted Suicide")

This returned 17 hits, of which I kept 4 that were in some way relevant.

I also decided to search the PubMed medical database using its equivalent of a thesaurus search on counselling, psychotherapy and suicide but this found nothing not already found on PsycINFO. A further ‘top up’ search of the most recent publications was carried out during the write up phase of the study but this yielded no new studies of any relevance.

Appendix II: Recruitment Poster

University of Chester

Counsellors:

Have you experience of *working with suicidal clients?*

Are you *interested in participating in research* into this vital area?

If so, then *I'd like to hear from you.*

My name's Mike Whitfield and I'm conducting research into counsellors' experiences of working with suicidal clients as part of an MA in Counselling Studies at the University of Chester and supervised by Dr Andrew Reeves. Initially I'd be asking you to complete a short questionnaire about your background, experience and current work, and then possibly take part in an in-depth interview at a later date.

Ideally you will have:

- At least a Diploma level qualification in the Person-Centred approach
- At least three years' post-qualification experience
- Regular supervision as per BACP guidelines
- Current or recent experience of working with suicidal clients

To discuss taking part, please email:

Appendix III: Information Sheet

University of Chester

Participant Information Sheet

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Research for the degree of Master of Arts in
Counselling Studies at the University of Chester

What do counsellors experience when a client says they're suicidal? What thoughts and feelings do they have and what impact does it have upon them? To what extent do they feel responsibility for the client? These are the areas I'm going to be exploring in this study.

You don't have to take part, and if you do, you are free to drop out at any time up until I submit my work for marking, in which case I'll destroy any records made of your contribution. Initially I'd like you to fill in a questionnaire about your background, experience and current work and then possibly take part in an in-depth interview at a later date. In the interview I would hope to explore what you mean by 'suicidal', your own beliefs about suicide, any policies and procedures you work to with respect to suicide and how you feel when a client tells you they want to die. In order to analyse the information I'll need to audio record the interview and make a transcript of it.

No identifying information about you or your organisation will be included in the research or any subsequent publications. Any record of what you tell me is confidential, will be used only for the purposes of this research and will be kept securely, accessible only to me, my supervisor, Dr. Andrew Reeves of the University of Chester and its examiners. The University requires that all written records be kept for five years and a final copy of the dissertation will be kept in the library, however audio recordings will be destroyed upon completion of the research.

If you have any questions or would like any further information about this research, then please contact me via email or phone:

Mike Whitfield
[redacted]

Appendix IV: Questionnaire

University of Chester

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Research for the degree of Master of Arts in
Counselling Studies at the University of Chester

Questionnaire

Thanks for agreeing to complete this questionnaire, it shouldn't take you more than about five minutes.

I'm currently studying for an MA in Counselling Studies at the University of Chester and am carrying out research for my dissertation into what counsellors experience when working with clients who express suicidal ideas and/ or intent.

The purpose of this questionnaire is to gather some general information from you about your training, experience, current work environment, the number of clients you're working with and how many have recently expressed suicidal thoughts.

No identifying information about you or your organisation will be included in the research or any subsequent publications. Any record of what you tell me is confidential, will be used only for the purposes of this research and will be kept securely, accessible only to me, my supervisor, Dr. Andrew Reeves of the University of Chester and its examiners. The University requires that all written records be kept for five years and a final copy of the dissertation will be kept in the library.

At the end of the questionnaire I'll ask you if you'd be willing to participate in a short audio recorded interview. If you agree then I may get back in touch with you in a few weeks to arrange this. You are, of course, free to drop out at any time up until I submit my work for marking, in which case I'll destroy any record of your contribution.

Thank you once again, not only for helping me in my studies but also for contributing to what I hope will prove a valuable piece of research into this important area of our work.

Mike Whitfield

[redacted]

The sections for you to fill in are all coloured grey. For Yes/ No type answers, just click the box to choose the answer you want. If you make a mistake, just click the box again to un-check it and click the one you want.

The longer boxes are for you to add text, just click in the box and type your response; the box will expand to fit what you type.

Please indicate your gender:

Female ☐

Male ☐

Other ☐
Please describe if you wish:

Please indicate your age:

18 – 24 ☐

25 – 34 ☐

35 – 44 ☐

45 – 54 ☐

55 – 64 ☐

65 – 74 ☐

75 + ☐

Prefer not to say ☐

How would you describe your ethnic/ cultural background?
(Leave blank if you prefer)

Please continue on next page…

Do you have a Diploma in Counselling?

Yes ☐

No ☐

If not, do you hold a professional qualification in therapy?

Yes ☐

No ☐

If yes, please indicate what it is:

What would you describe as your main therapeutic approach?

Please tick one only:

Psychodynamic ☐

Cognitive-Behavioural ☐

Person Centred ☐

Other Humanistic ☐
(e.g. Gestalt, T.A.)

Existential ☐

Integrative ☐

Don't know ☐

Other ☐
Please indicate:

Please continue on next page…

How long since qualifying have you been working as a counsellor?

Less than 3 years ☐

3 - 5 years ☐

6 - 8 years ☐

9 – 10 years ☐

11 – 15 years ☐

16 – 20 years ☐

Longer than 20 years ☐

Do you currently receive specific ongoing supervision for your counselling work?

Yes ☐

No ☐

Do you work to any recognised therapeutic Code of Ethics and Practice?

Yes ☐

No ☐

If yes, please give details of which organisation:

Please describe the client group with which you predominantly work:

Please continue on next page…

In which environments are you currently working as a counsellor?

Please tick all that apply:

- Local Authority ☐
- NHS Trust/ Local Health Board ☐
- Increasing Access to Psychological Therapies (IAPT) ☐
- Employee Assistance Programme ☐
- Voluntary Agency ☐
- Private Practice ☐

How many clients are you currently working with in Counselling?

Of the clients you are currently working with, how many would you describe as 'suicidal', or have recently expressed suicidal thoughts?

Do you include any reference to 'suicide' or 'self-harm' in your therapeutic contracts, i.e. with regard to confidentiality?

- Yes ☐
- No ☐

Please continue on next page…

At this stage, is there anything else you would like to add about yourself as a counsellor and your work with suicidal clients?

Would you be willing to participate in an individual, audio recorded interview to discuss your experiences of working with suicidal clients in more detail?

Yes ☐

No ☐

If so, please complete your details below:

Name:
Email:
Phone:
Address:

Thank you once again for filling in this questionnaire.

To return via email, in MS Word, choose 'Send To' from the 'File' menu and copy and paste my address below into the 'To' field. Or just save the file once completed and attach to an email as you would normally.

If you have any problems with this method then please email me and I'll send you a hard copy to fill in along with a stamped addressed envelope.

Thanks again,

Mike

Appendix V: Interview Guide

Counsellors' Experiences of Working with Suicidal Clients

Working environment/ Context

- Working policies/ procedures re: suicidal clients
- Employer expectations?
- Do you assess as well as counsel? Differences between assessment and first counselling session – will look at contracting next
- Referral processes - assessment criteria for therapy
- Risk assessment – how? Forms, documents? How important is this?

Counselling agreements/ Contracts

- Processes of making agreements with client
- References to suicide, re: confidentiality
- Reasons for breaking confidentiality

Own views and beliefs

- Own personal views and beliefs about suicide
- Role of counselling with suicidal clients
- Impact of training in counselling with respect to own beliefs – was suicide dealt with as an issue in training?

When a client says they are suicidal… (Thoughts and Feelings)

- Thoughts and feelings about the client for saying it?
- Thoughts and feelings about yourself as a counsellor?
- Appropriate responses?
- Awareness of own feelings then - and now
- Relate back to agency policies / procedures
- Relate back to own views about suicide

What do you do when a client says they are suicidal?

- Your thoughts / feelings about how you worked with situation
- Does anything remain ‘unsaid’ to client?
- Use of supervision - how easy / difficult - response of supervisor

The Issue of Responsibility

- In your counselling practice as a whole, how much responsibility do you feel you take for your clients, as opposed to how much you feel they should take for themselves?
- How does this change when a client says they are suicidal?
- How much responsibility do you feel you should take for a suicidal client? Why? How effective do you feel this is in your work with them?
- What would happen if you did take more responsibility?

Anything else you wish to discuss?

- Comparing self to other counsellors - what is your guess about what they would say?
- Outstanding issues from this interview?

Thanks!
Transcript copy? Member checks?

Appendix VI: Introduction to Interview

MA Counselling Studies
Semi-structured Interview

Introduction

To be read to all interview participants

The purpose of this interview is to talk in more detail about your experiences of working with clients; specifically those who you have suggested in the questionnaire are suicidal.

In the questionnaire you stated that _____ of the clients you are currently working with are suicidal. Is this still correct?

You also said that you are in ongoing supervision, is that still the case?

The research I am doing is for an MA degree in Counselling Studies. I am looking at what the counsellor experiences, including their thoughts and feelings, when a client says that they are suicidal. I am hoping to learn more about the impact on counsellors of their clients talking about suicide. There is little research in this area and it is likely that most counsellors will experience this situation at sometime in their professional work. In the interview I hope to look at what you mean by

‘suicidal’, your own beliefs about suicide, any policies or procedures you work to with respect to suicide and how you feel when a client says that they want to die.

My research is being supervised by Dr Andrew Reeves from the University of Chester. I will be interviewing between four and eight people in total and will be covering the same topic areas. As a way of analysing the information it will be important for me to make a detailed, accurate record of this interview. To do this my intention is to make an audio recording.

Your identity and that of your organisation will remain absolutely confidential and information obtained will only be used for the purposes of this research and any subsequent publications based upon it.

I will make a written transcript of the audio recording and that transcript will not be associated with your name or organisation. In addition to myself, staff and examiners of the Department of Social and Communication studies may read material from this transcript for the purposes of assessment and moderation, all of whom are bound by the British Association of Counselling and Psychotherapy’s Ethical Framework with regard to confidentiality.

The University requires that all written records be kept for five years and that a final copy of the dissertation be kept in the library but audio recordings will be destroyed upon completion of the research. All records will be held securely.

You may choose to withdraw at any time up until the work is submitted for marking, in which case any records made of your contribution will be destroyed.

Are you happy with these arrangements?

The interview will last approximately one hour.

Do you have any questions before we start?

BEGIN RECORDING

“This is an interview for a research dissertation as part of an MA in Counselling studies at the University of Chester, between Mike Whitfield and _____, taking place at _____.

The date is _____ and the time is _____.

Your identity and that of your organisation will remain absolutely confidential and information obtained will only be used for the purposes of this research and any subsequent publications based upon it.

I will make a written transcript of the audio recording and that transcript will not be associated with your name or organisation. In addition to myself, staff and examiners of the Department of Social and Communication studies may read material from this transcript for the purposes of assessment and moderation, all of whom are bound by the British Association of Counselling and Psychotherapy’s Ethical Framework with regard to confidentiality.

The University requires that all written records be kept for five years and that a final copy of the dissertation be kept in the library but audio recordings will be destroyed upon completion

of the research. All records will be held securely.

You may choose to withdraw at any time up until the work is submitted for marking, in which case any records made of your contribution will be destroyed.

Are you happy with these arrangements?”

Appendix VII: Audio Recording Consent Form

University of Chester

Audio Recording Consent Form

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Research for the degree of Master of Arts in
Counselling Studies at the University of Chester

I, _____, hereby give consent for the details of a written transcript, based on an audio recorded interview with me, to be used as preparation and part of a research dissertation for the MA in Counselling Studies at the University of Chester and any subsequent publications based upon it.

I understand that, without my further consent, the transcript material used in the dissertation, and possibly the full transcript, will be read by the student conducting the research and also Department of Social and Communication Studies staff and examiners for the purposes of assessment and moderation. I understand that all of the above are bound by the British Association for Counselling and Psychotherapy's Ethical Framework with regard to confidentiality. I understand the Department of Social and Communication Studies staff who are responsible for receipt, transmission and storage of dissertations are also bound by the BACP Ethical Framework with regard to confidentiality and agree to respect my right to confidentiality in their handling and storage of transcript material, and that no further use will be made of this material by them without my further consent and that of the student submitting the dissertation.

I understand that any record made of my contribution is confidential, will be used only for the purposes of this research and any subsequent publications based upon it and will be kept securely. I understand that no identifying information about me or my organisation will be included in the research or any subsequent publications. I understand that the University requires that all written records be kept for five years and that a final copy of the dissertation will be kept in the library but that audio recordings will be destroyed upon completion of the research. I further understand that I may choose to withdraw at any time up until the work is submitted for marking, in which case any records made of my contribution will be destroyed.

Interviewer:	***Interviewee:***
Name: _____ *(Please print)*	**Name:** _____ *(Please print)*
Signed:_____	**Signed:**_____
Date: _____	**Date:** _____

Appendix VIII: Units of Meaning

Unit of Meaning	Participant	Page, Line	Theme
P I think… my interest stems from the fact of working with… young people who are very vulnerable and who have expressed either strong suicidal thoughts or have attempted… or that intent… and erm… when I reflect on it, it's really that dilemma or that challenge of working through… the… with somebody who is young, who is in that vulnerable position and what I can do that best supports that… er… yeah… and the challenge around that.	1	1, 8-14	Perceived vulnerablity of young people
P …it's the two things together, when I think about the students that I have worked with who have expressed suicidal thoughts or attempts… they are young and vulnerable, so there's something about that… young and vulnerable and reaching that point of… that… a depth of despair that they are experiencing those thoughts or having… er… you know, have that plan or intent… and the challenge around that.	1	1, 24-29	Perceived vulnerablity of young people
P So I think there's something about that vulnerability around somebody young that makes a difference	1	2, 4-5	Perceived vulnerablity of young people
P So that's a written contract that all clients that we see regardless of age… erm… sign in their first session and we outline very clearly when that confidentiality may have to be… erm… er, broken… and that is around either an expression of strong suicidal thoughts, or an attempt, or an intent.	1	2, 31-35	specific written contract
P Yeah, so that's in the contract and then we have our organisational policy which is a safeguarding policy which covers all other areas of safeguarding, which covers all other areas of er… safeguarding like physical abuse, erm, sexual abuse, er, those key areas… of… of which a vulnerable young person may fit into that as well and a vulnerable adult… So the two almost go together… so, and there can be a challenge regarding that and maybe that'll come up later?	1	3, 5-11	organisational safeguarding policy
P …as well, so we've sort of tried to cover both er, sets really if you will, and find a contract that erm, both safeguards us and safeguards the client and meets the organisational erm… requirements. M Yeah. P And it's always a challenge! (laughs) M It sounds like… P It's never black and white! It's always grey… M Yeah, cause it sounds like you're almost trying to please two masters… P Yeah	1	3, 36-50	Conflicting policy demands
P Well, no, I say massively. I say, there are situations where erm… I don't know whether necessarily around suicide… Let me think Mike… Yeah… there are situations where a student may express suicidal… they've had suicidal thoughts… erm… where ordinarily, you know, by the contract you would break that confidentiality but I've made that decision to hold that situation and not involve, not break that confidentiality…	1	4, 16-21	Holding the situation- not breaching according to contract
M So you do have a certain amount of latitude… P So the… M …within your role do you? P Yeah. Yes… and I can justify that within the BACP kind of guidelines	1	4, 27-33	Justifying working to BACP guidelines instead of organisational policy
P So I can justify those decisions around that young person… So… I think more often than not I would probably break that confidentiality to safeguard the client, I must say… but I know there have been situations where I haven't. I think I've got to be careful… I think… what I've got to be careful here for this interview	1	4, 37-41	Holding the situation- not breaching according to contract
P I'm just saying that 'cause I realise that I could get both of those things, so there might be for instance a student who's feeling suicidal, or having suicidal thoughts but there's other issues around that situation where they don't want me to break that confidentiality because it could make the matter worse	1	5, 9-13	Holding the situation- not breaching according to contract

P	Erm, even when I think of the referrals from the outside agencies, which are few I think, more in the minority… erm… more often than not it comes with very little around the risk area			Referral - no prior information
M	Mmm	1	8, 3-16	
P	So really we're working very much on the edge and very much in the immediacy…			
M	Mmm			
P	…of what comes through the door. So often it can be a crisis situation and either the student just appears or they're brought down by somebody and there's no pre-assessment done…			
M	So that sounds as though then, in that case, do you actually go through any kind of process in terms of assessing the risk?			Assessment, dialogic and continuous, client's 0-10 rating
P	Erm… when the session starts, then I guess I am assessing all the time…	1	8, 23-48	
M	Yeah			
P	…so that assessment will be happening… if somebody discloses that they are feeling suicidal, or if I sense that er… I am concerned of what I'm experiencing or hearing then I may check with them where they are…			
M	Mm			
P	…are they having suicidal thoughts or if they mention they're having suicidal thoughts I might do a scale of 1-10			
M	Mm			
P	…and work that way, you know, 10 is taking your own life, where are you on that scale…?			
M	Yeah			
P	So that's probably the most I would do in a session			
M	So I can see what you mean, you've talked about 'being on the edge' several times, you've used that, and it does feel as though its where 'Bang', here's this person… crisis, you know, I've not actually got… nobody's actually sort of assessed them for me, I've not got a…			Referral - no prior information
P	No	1	10, 5-25	
M	…whatever… they've appeared, here's the crisis, and now I've got to sort of deal with they're giving me and somehow…			
P	That's right			
M	…work with what's emerging and try to sort of… in terms of any suicidal feelings, then that's an exploration you're having to do within that first meeting with them			
P	Mmm. Yeah, that captures it pretty well			
M	Yeah… yeah			
P	(laughs) Yeah, absolutely it does!			
P	So… I guess that does capture the… two kind of predominant scenarios that happen, erm… so in a crisis situation, erm… I would always verbally contract, so even if a student is very distressed…			Verbal contracting in crisis situation, paperwork inappropriate
M	Mm	1	10, 46 - 11, 14	
P	Erm, in some way within those first few minutes, erm I will ensure that I will verbally, you know, ring fence those boundaries, get across when I might have to get somebody else involved, particularly around suicide and attempted suicide			
M	Yeah			
P	Erm, and do that verbally…			
M	Yeah			
P	…it's not appropriate to have a load of paperwork…			

P If a client has prebooked a session, erm, so er, I'm… they know and I know that that's coming up, er, it's much easier to do the formal contract, at the beginning of the session… M Mm P …and er, yeah, I take the time to outline very clearly what the boundaries are about self harm…	1	11, 17-24	Formal contracting. Being specific about self harm
P Yeah! …and I think it helps, whenever it happens, it always… kind of brings me up short really in a sense… I can get… there is a danger that I can get quite complacent with going through the boundaries of confidentiality…	1	12, 11-14	Danger of complacency in outlining boundaries
P …the boyfriend that's run off with their best friend and they're fed up with him, and they don't want to hear about the contract and, and to sign anything. So when somebody does say '…what do you mean by… ?... Who do you mean you'll tell…? Then, erm, you know, I think, it's always good to hear that, and I think it's good for me to prevent that complacency, it's so important.	1	12, 24-29	Danger of complacency in outlining boundaries
M So yeah, it feels as though that can impact on whether they feel comfortable working with you once you've stated those boundaries… P Mm M …if there's a possibility of it going somewhere else I may not be able to… P That's right M …I may not be able to work with you P That's right	1	13, 2-14	Concern that client will not continue because of confidentiality boundaries
P Erm. it's very hard, erm… because. and I guess… I guess I've worked out a lot of different ways. because often they don't want to disclose what's happened. First of all, there's two things really. I mean first of all I always outline that it's not about self harm, 'cause I think when they hear intent to suicide, suicide, harm to self, it can be about self harm… M Yeah P …and er, you know, we always work with… we work with a lot of students who self harm M Sure, so it's important for you to be able to make that distinction…? P That's right… that's right. I think when a student is very hesitant or looks very anxious about who may be informed, erm, sometimes we'll do a hypothetical scenario…	1	13, 18-33	Being specific about self harm
P That's right… that's right. I think when a student is very hesitant or looks very anxious about who may be informed, erm, sometimes we'll do a hypothetical scenario… M Mm P I'll talk about a student who… 'well, let me give you an example of a situation and what might happen' and see if we can create more safety erm, in that way, but still they may make that decision not to come back or…	1	13, 31-40	Use of hypothetical scenarios to illustrate confidentiality boundaries
P I'll talk about a student who… 'well, let me give you an example of a situation and what might happen' and see if we can create more safety erm, in that way, but still they may make that decision not to come back or… M Mm. P …or go away and think about whether they want to come back or not. So it can be hard I guess you're question was 'where did that leave me?' M Yeah P It can be hard because you are faced with a student who I know is carrying or holding something that is…	1	13, 37 - 14, 23	Concern that client will not continue because of confidentiality boundaries

M	Mm			
P	…obviously something quite distressing and quite difficult…			
M	Yeah			
P	Erm… but is frightened or scared around sharing that			
M	So, it feels as though that could be difficult for you possibly, or you can feel that the student has these issues that you could work with, but because they're not comfortable with the boundaries that you have to work in…			
P	Mm			
M	…they're choosing not to…			
P	Mm. Mm			
M	…and they're going away again…			
P	Mm… that's hard			
P	So if they were an adult making that informed decision… erm… yeah… they may still be as vulnerable, but there's something about being an older adult, it's easier, that being able to trust that they are able to make that decision…	1	15, 20 - 16, 10	Perceived vulnerablity of young people, Wanting to do more
M	Mm			
P	…and having more of a support network to deal with that…			
M	Yeah			
P	Because a lot of our young people come from very dysfunctional backgrounds, erm… where they haven't got a good support network… and I think then they can be very isolated, very alone with that…			
M	Mm			
P	…and that then is a hard thing to know that they're going out there… back out into their world…			
M	That does feel especially hard then…			
P	Yeah			
M	…doesn't it? I can see what you mean…			
P	…carrying something that is quite heavy			
M	…someone considering ending their life… is gonna kind of pull at you anyway…			
P	Yeah			
M	…but when they're young and vulnerable, etc, that sounds like that makes you feel you want, you are wanting…			
P	Yeah			
M	…to do more maybe but not being able to…			
P	Yeah… yeah			

P	So… I… erm… I take the student's information first… and then before I go on to further information I'll then outline… outline the boundaries. So this is just a tick list, a reminder, when we have students on placement that they remember what to do. So the first thing I will do is talk to them about confidentiality…	1	16, 25 - 17, 23	Formal contracting
M	Mmm			
P	…talk to them about the boundaries of confidentiality and… because it's very clearly set out in our contract, the exceptions to breaking confidentiality…			
M	Mmm			
P	…I will be saying to them, suicidal thoughts or intents or that intent to harm themself, so at that point, when I'm talking about that, erm… that's when they can often say 'Oh no, no, no! I'm not at that point!' you know, you know…			
M	Yeah			
P	…but I suppose all the time before that stage or at that stage there is			

	sometimes I've said it and they've just burst out crying…			
M	Mmm			
P	…erm… 'cause I think it really connects with where they're at. So it is quite a crucial part and then it is something that I'll do at the beginning			
M	Mmm… so that kind of introduces…			
P	…that introduces it yeah…			
M	…it for you and then…			
P	Yeah			
M	…so you don't necessarily have to introduce…			
P	Yeah			
M	…the subject yourself…			
P	No			
M	…the process is doing it			
P	No, in crisis situations and doing it verbally, I'm still using similar wording, so I guess that introduces it at that point			
P	…but… where things have been very difficult and quite dark I guess, but I've never reached that point where I felt suicidal myself…	1	18, 1-13	Hard to empathise with suicidal feelings if you've never had them
M	Right			
P	Erm… I may… I don't ever feel judgmental to somebody who does but I think it makes… I think I do struggle… struggle erm, not to empathise… 'cause I do empathise… but it… it's getting that connection… that full connection with somebody who has reached that point…			
M	'cause it's something you've never felt yourself			
P	…something I've never felt myself, that's right			
M	But at the same time, because it's something you've never felt or never considered…	1	18, 27-39	Hard to empathise with suicidal feelings if you've never had them
P	Yeah			
M	…it's perhaps harder for you to… to empathise exactly with where they're at…			
P	Yeah			
M	Because it's something that's alien to you?			
P	Yeah… yes, I think I feel that's more it really			
P	I think if I experience any difficulty I guess it may come out… I guess its… it's more of a helplessness… than I don't really connect with what's going on here. So I think when I'm working with somebody who is feeling suicidal or has that intent, it's more that feeling of 'how can I help this person, I hope I can do enough'…	1	18, 44-48	I hope I can do enough
M	…and that's actually the next… the next subject area is really what you feel is the role of counselling therefore when somebody is perhaps having suicide… what do you feel counselling can do, in that case, if you're perhaps feeling helpless as a counsellor… what do you feel counselling can do for them?	1	19, 13-39	Value of offering space to speak about suicidal thoughts
P	I… I think… I think the important thing is… to offer them that space where they can express those thoughts…			
M	Mm			
P	…'cause often… my experience has been that they haven't told anybody else and I think just by expressing them within that confidential space, within that safe space…			
M	Mm			
P	…erm… it seems to be, all my experience is it's a huge relief, and I think if I'm able to be, to offer that relationship that accepts that, that will work with that, that doesn't panic around that…			
M	Mm			

P	...erm, much as I may well have to inform somebody that I'm working with somebody very vulnerable, erm... you know... and would discuss that with the client, erm, I think that just the fact that they're able to express that... is... is what I feel the powerful nature of what I can do...			
P	That is right, so... there's something I think... there's something around the client's vulnerability when they are expressing that, that somehow feels as though I want to offer more...	1	20, 29-36	Wanting to do more
M	Yeah			
P	...or to put some kind of... to use Andrew Reeves' term, you know a safety net there			
P	Erm... Erm... ... So I think the challenge really, it's when that session's ended, it's trusting that the client is going to be safe... and I think again it comes back to because they are a young person, because often they don't have a good support network, it's 'have I done enough to support them until the next time I see them or until erm... you know, I see them the next day or I see them the next week'. So have I done enough?	1	20, 40-50	Have I done enough? Trusting the client, difficulty of
M	'Have I done enough?' ...yeah			
P	Have I done enough? That's the helplessness. Have I done enough to offer that support?			
M	...'I feel I want to do more, particularly because they're young and vulnerable'	1	21, 12-16	Perceived vulnerability of young people. Wanting to do more. 'What if?' anxiety
P	Mm, mm... and I think there's anxiety and fear around 'what if?' 'What if I have done all that I can and they still take their own life?'			
P	...yeah. I think... that haunts me. If I'm working with somebody like that, I think that's always there in the back of my mind, 'what if they did and where would that leave me?' ...Erm...	1	21, 24-26	What if?' anxiety
P	No, it kind of feels selfish- 'well what about me?' but... it is that feeling of, first of all, organisationally what would happen, you know, erm... but also... you know, emotionally... er, where would I be left...	1	21, 43-45	Consequences of client suicide- professional and emotional
P	...if that client... you know, we talk about trusting the process don't we, trusting the client...	1	21, 49 - 22, 11	Trusting the client, difficulty of
M	Mm			
P	...trusting that any decision they make will be beneficial and the right decision for them...			
M	Mm			
P	...that actually, to trust that you know, if they take their own life, that was the right decision for them... it feels as though it would be quite difficult to be with			
P	Mm... mm... and I think, listening to that, erm... I think because taking my own life would never feel the right decision... I think I would find it quite hard if someone I was working with took their own life... to fully accept that that was the right decision for them	1	22, 21-24	Hard to empathise with suicidal feelings if you've never had them
P	Because of that... yeah, I think because of the sanctity of life, I think because I haven't experienced reaching that point maybe, it's difficult then... yeah... it's tough isn't it, when you start to explore it? (laughs)	1	23, 4-6	Hard to empathise with suicidal feelings if you've never had them
P	I think it's more the workshops that I've done since because of the level of work that I do here	1	23, 15-21	Post qualification training in suicide. Vague memories of training
M	Mm			
P	I don't particularly remember, of course it did come up in our skills work, erm, but we didn't specifically focus on working with the suicidal client			

P …I'm anxious, I know, I know that happens, so I think on the outside I'm able to stay calm, I think emotionally, inwardly, I do feel quite anxious… erm… and I think that that stays with me until I make more of an assessment of what that is, so is that, are they going to walk out of this room and jump off the bus station or actually, do they… I often say to students, and it's often something that when it comes up we talk about, that some people, you know, express that they want to, that they're feeling suicidal, but it's more that they want all the crap to stop than they want to die	1	24, 13-21	The Swan'. Anxiety-driven exploration of extent.
P …'cause usually what they say is, 'oh yeah, it's just I want all this crap to stop' or 'I want to feel better', or 'I wish things would just improve', or something like that, rather than actually they have a plan, they have an intent, so I think initially there's that anxiety when somebody expresses it	1	24, 29-32	Initial panic/ anxiety
P …and I think the anxiety then is attached to erm… what do I need… what is the expectation of me then, or what do I need to do M …there's a feeling of expectation, of pressure almost? P That's right, that's right… M …on you… P …to ensure the safety of that young person. So is that going to mean I'm going to have to involve lots of other people, or actually is it that the student is just wishing all the crap to stop, you know… and it can be anywhere inbetween that. Erm, and actually they don't want to die, they're not going to take their own life, 'oh no, I haven't got a plan' and that reassurance kind of comes out, so it's not like that's negated, 'cause I think it's important to acknowledge that the struggle, the issue they're having, has reached that depth where actually…	1	24, 29 - 25, 5	Anxiety-driven exploration of extent. Feeling some responsibility for the suicidal client
P …they've thought it would be easier to die or- but they don't want to die… you know, and I guess it's doing, it's exploring that further, so it's slowing that down. But I think part of slowing that down is slowing that down for me as well. M Right P So being able to slow it down for them also help with my anxiety to kind of slow things down.	1	25, 9-17	Putting the brakes on'
P Yeah… yeah. …and I think the anxiety is that if, if that's not, you know, if there isn't that reassurance there	1	25, 39-40	Anxiety-driven exploration of extent.
P Yeah… yeah. …and I think the anxiety is that if, if that's not, you know, if there isn't that reassurance there, I'm particularly thinking of some, quite a few young people I've worked with who are having suicidal thoughts, this is where there's that grey area. So actually, if somebody's saying they have an intent, I've got tablets in my bag, I'm going to go out of here and do something, that's almost easier to work with than someone who's saying 'I just sometimes feel as though I want to end my life' M So it's more… it's more black and white in some way? P That's right M That's a clear… P The intent is black and white, I do need to get somebody else involved, we do need to inform a GP or maybe take them down to the [……] suite, or do something if they've reached that real crisis pitch- it's almost like the students who… come under that grey area where they might be having quite strong suicidal thoughts but there isn't an intent, that they're on that edge M …and it feels as though that's more difficult because it's not black and	1	25, 39 - 26, 21	The grey area

white, it maybe that involves you having to make a decision in some way, I've got to assess is that… what that risk is… P Yeah M …and what I need to do about it. It feels more pressured then? P That's right. And it's me, perhaps taking that risk of holding that space, holding that student, trusting them in that… that I will them see them next week, that they won't then take their own life, or they will come and contact me or, if that changes			
P …erm, so all those safety nets are in place, erm, but I know that they are still on my mind, so I will go home, erm, it's not down to myself, and it's not down to them, but it's just holding something that feels very… erm… …I don't know… risky…	1	27, 4-7	Feeling some responsibility for the suicidal client
P It's that 'but what if…?' and I think it's that bit that's a risk, so I kind of put all those safety nets, as Andrew Reeves would say, in place M Mm P But it's that 'what if…?' what if something changes and they do… jump in front of a train	1	27, 24-30	'What if?' anxiety
P …that feels very different to any other issue, you know, it just feels very different M What is it that makes it feel different to any other issue? P 'cause it's life and death… if that person…	1	27, 44-49	Life and death, finality.
P …there is something about that loss of life… something about the finality M Yeah… and it's almost like, there's one chance… P That's right M …and once they've done that, they've done that, whereas they could always leave the abusive relationship somewhere down the line, it could be managed while they're in it possibly, erm, but when they're dead, they're dead. P Gosh, that sounds… M (laughs) It does… actually, when you say it like that… P …it does when you say it, once they're dead…	1	28, 13-28	Life and death, finality.
P …(laughs) …what do I feel about the client…? …I'll be dead honest now (smiling) … I think… (laughs) It's awful isn't it, when you really think what you think… 'cause I think there are times I think 'I wish I hadn't said that' M Yeah P …is that awful to say that? It's awful to be honest isn't it? (laughs) M So what makes you think that, what makes you feel… P I think for me that captures the kind of… the difficulty- not the difficulty… the pressure that I feel under once it's disclosed	1	28, 47 - 29, 8	Opening a can of worms.
P …once it's out there, once they've said… and 'I'm experiencing suicidal thoughts' or 'last night I nearly did this', you know, it's almost like… 'Oh, gosh, I wish I hadn't done that!' M So it's out there now… P It's out there now… and it's out and we have to work with it and I have to work with it, and I have to ensure your safety in a sense… M So it almost feels like they've kind of put it on you in some ways, it's like now you've said that, you've kind of… now you've left ME with it in some way… P It feels like it… it feels like a huge responsibility…	1	29, 16-35	Opening a can of worms.Feeling some responsibility for the suicidal client

M Right P ...so, I think it feels like a very responsible position that I feel in anyway erm... working with young people, it's almost like, once that's been disclosed, then it ups the ante... we're into a different level			
P ...I think sometimes... those policies and that contract that we've set up... can feel vital, and thank goodness it's in place...	1	30, 9-10	The reassurance of policies and contracts
M So, are you saying that in some ways, it's important because if it makes it clear, like you say, if there's intent, right, it's clear what I have to do there, so it's almost like, I don't have to make the judgement there, you've signed the contract, that's what the contract says, that's what I do, no problem with that. Where it's a grey area, the responsibility then falls on you to make the judgement, which is about potentially about somebody's life, as we said, and that then feels like that's more responsibility... P Mm M ...where it isn't actually clear, or it leaves the judgement down to you...? P Mm... and I think even when a student is expressing the intent, it can still be a hard call, it can still be quite difficult to break that confidentiality. Thinking of one particular student who begged me and... and pleaded with me not to inform anybody else and I had to go against that...	1	30, 17-33	The grey area
P ...so that's ok if that client's on board with that... and I suppose that's maybe different, so often they have shared that looking for your help, and they're quite relieved that other people are going to be involved or were going to give you that support... it's a different kettle of fish isn't it, if a client then doesn't want you to. M So even when they've signed the contract... P That's right, that's right... M ...that says you will, they don't want you to... P ...yeah M ...and you have to anyway... P ...and that feels incredibly hard... and I can think of at least two students that I've worked with, so it doesn't happen often... erm... where I had to go against their wishes, and that was very difficult	1	30, 37 - 31, 5	Difficulty of breaching against client's wishes
P Mmm... emotionally. So at head level, up here, you know, black and white, you know, it kind of sounds very simple, if you express suicidal thoughts, that you've attempted suicide or you have that intent to harm yourself, I will have to do this. I think at a head level it's very clear, at an emotional level I think it's a lot harder	1	31, 31-35	Cognitive/ emotional split
P I think, predominantly I felt I was erm... kind of betraying her in some way, letting her down, I was going against something, and I guess this is where that er, particular situation was very complex...	1	31, 39-41	The emotional contract' - betraying this
M Yeah... and it's interesting, you're almost, when you describe that it almost feels as though there are two different levels of things going on, there's the sort of erm... this written contractual arrangement where everything's very clear, you know, I made this clear to you, you've signed it, you tell me this, I do that- where's the problem? But it almost feels as though on an emotional level it feels as though there's almost like an emotional contract which actually has different boundaries... P Oh definitely... M ...almost as though, well actually, I shouldn't be doing this... P I think emotionally... you know, it shouldn't have, but it does, and I think emotionally, because of that relationship, because of the trust that's built up- 'cause I think by that stage I think I'd been working with this student	1	32, 1-17	'The emotional contract' - betraying this

for over two years, though it wasn't two full years [academic years] so it would have been about eighteen months altogether			
P Mm. I think that I always respond in… a very… erm… calm, reassuring way. So much as there can be a lot going on emotionally, a lot of anxiety… I would like to think that I still offer that relationship where they can express exactly what's going on for them…	1	32, 49 - 33, 2	The Swan'. Value of offering space to speak about suicidal thoughts
M But it's almost like, I'm having to kind of be… be different to how I'm actually feeling in some way… P Mm… M …because that's what I feel this person needs… P …definitely…	1	33, 20-27	'The Swan'.
P …definitely… I guess it's putting that anxiety to one side really, so it's knowing it's there, I know it's there, but I think what's important for that client is… giving them that space to explore that and to some extent slowing that down… and I think that's quite key for me really, quite key for my anxiety but also I think important for them… M Yeah, and you said that before, didn't you… P …to slow that process down… M …to try and actually slow that down, it feels like trying to manage it… P That's right, let's really manage this, let's really explore what this means for you and what this means for me	1	33, 31-44	The Swan'. Value of offering space to speak about suicidal thoughts. 'Putting the brakes on'
P Mmm… and I think the congruence bit is perhaps sometimes expressing… it's not expressing that anxiety but I guess it's about expressing my concern sometimes around their safety, so perhaps sometimes I've explored with them, erm, who is there, let's look at who there is at two o'clock in the morning and you're feeling suicidal and they say there's nobody there, I may then offer my concern – 'Gosh, I feel really anxious and concerned when you say that, there's nobody there and I think it's really important that we work hard to look at what we can put in place'	1	34, 1-9	Congruent concern'. 'Putting up the safety nets'.
P You know, usually they're fine… more often than not it's that they don't want their tutor or their… parents to know and I think when you reassure them, so often when I tell [….] afterwards, erm… no action is taken, we just hold that situation together, it helps me if I've shared it, 'cause I then know, that if anything happened, somebody else in college knew about it M That feels like that's then less of a burden…? P Yeah… it lessens the pressure	1	35, 19-27	Sharing or passing on the burden of responsibility
P It is, it is, so… and I think more often than not, when I talk to my supervisor about it, so [….] knows that I will phone her if I'm holding something or carrying something, er, 'cause it feels quite a pressure, so usually it's when I've decided not to inform the DSP, so I'm holding the situation and I just need to just inform her and talk through, you know, what I've decided to do, have I covered all the bases, is there anything else I could do in that situation	1	35, 37-43	Sharing or passing on the burden of responsibility. Have I done enough?
M But it's still, it's about sharing things, one's about officially sharing something and the other one's… P That's right M …about checking things out and… as well P That's right M 'Have I done enough' it almost feels like that would… P That's right, that's right M …be the question you'd be asking it feels	1	36, 4-17	Sharing or passing on the burden of responsibility. Have I done enough? Importance of good relationships with superiors.

P	And sometimes I can get that from the DSP, because [……] and I have worked together for a long time and I know that if I say to her 'I don't want anything more done and I'm just sounding you out here, I don't want anybody else involved' I can trust her with that. She can override me but I know her well enough to know that she will trust my judgment, it's just something that we will share M So it sounds like the relationship between you is important there… P Yeah	1	36, 19-28	Importance of good relationships with superiors.
P	…erm… my supervisor is very… I guess she offers me what I hope I offer my clients… so I guess what happens there is she remains very calm, very steady, explores fully the situation and if there's anything that she feels I could have done more with or I could have put in place then she will offer that. But I suppose what she gives me is that safe space… erm… to explore that really	1	36, 34-39	Supervision as a safe space
P	Not fully emotionally acknowledged, you know, erm… I think that's probably part of the anxiety is that feeling of 'oh no!…' you know that kind of feeling of 'oh…!' it's that that can be there M Is that kind of when they first express those feelings, that kind of 'Oh no!'? P Yeah M …sort of… P 'Oh no, we've got this' M Yeah P 'Oh no, I wish they'd not said that' M Yes P It's that, it's that, and I guess that's part of that anxiety or 'what am I going to be working with here'	1	37, 28-48	Anxiety-driven exploration of extent. Initial panic/ anxiety
P	Mmm, and I think probably, you know, I can remember feeling I guess that does subside, and it can subside quite quickly once we've done that slowing down and exploring or looking at what we mean by that, very quickly that can subside, you know, it can be there, a bit like and adrenaline burst isn't it, you know- (sharp intake of breath) 'Oh no, I wish they'd not said that!' M Yeah P 'I don't know, what am I going to deal with?' …and slowly with reassurance of where they are, of what that means to them what support they have, that can subside…	1	38, 6-17	Anxiety-driven exploration of extent. Initial panic/ anxiety.
P	It's interesting, as you were talking there… it's interesting, the difference in reaction to say somebody who's saying that they've been in a domestic violence situation… it's not that same powerful surge really, of somebody saying 'I'm feeling suicidal'… M Mm P …I've thought about taking my own life… it has a very different kind of feel	1	38, 37-45	Initial panic/ anxiety. Life and death, finality.
P	So I guess… erm.. yeah, I guess I'm, because of the predominant age of the clients that I work with, I think I take more responsibility than I would with other clients, erm… with adults	1	39, 19-21	Perceived vulnerablity of young people. Feeling some responsibility for the suicidal client
M	…you feel that you do take… a degree of responsibility and more than you would if they were adults P I don't know whether I take or… is take the same as feel. I guess I feel that responsibility… M That's an interesting…	1	39, 32-42	Perceived vulnerablity of young people. Feeling some responsibility for the suicidal client

P	...and possibly I take that responsibility as well, erm, I know that I work... harder in that counselling relationship because of the age of that client than I used to perhaps on placement or with adults			
P	So there's something about being able to sit back more if I'm with an adult student than with somebody who's a younger student- depending on the issue... but I hold that responsibility more	1	39, 46 - 40, 8	Perceived vulnerablity of young people. Feeling some responsibility for the suicidal client
M	So you FEEL more responsibility, you TAKE more responsibility in the sense that you feel you're having to work harder...			
P	Yeah			
M	...and actually sort of do more			
P	Yeah, I do			
M	...with that particular client group, and when that, when one of those clients says they're suicidal, how does that then change?	1	40, 14-30	Perceived vulnerablity of young people. Feeling some responsibility for the suicidal client
P	(laughs) Ups the ante!			
M	(laughs)			
P	Yeah, yeah, definitely. Ups the ante. Erm, yeah, I think the responsibility can be a lot higher			
M	So you then feel much more...			
P	Yeah			
M	...and you feel it and take it			
P	...and feel it and take it, definitely			
P	Yeah, I do feel it's necessary, erm... and I do feel it's important and I do feel, well, what is effective, I guess erm, so if, if we lost a client, if a client did... of mine or of my colleague's did commit suicide, would that feel as though we failed? I don't know, I guess it would.	1	41, 14-17	Client suicide as a professional failure
P	...and I think that, because the organisation puts such a weighting on the safeguarding of the students, so, so it would be hard to kind of view that as 'that was that client's responsibility and they should be allowed to decide for themselves whether they live or die'	1	41, 26 - 42, 5	Client suicide as a professional failure
M	Mm			
P	...erm that feels though, it's very hard to view it that way, it's about, you know, a number of people have said to me 'the counselling service has never had a suicide', and that feels a pressure in itself, it's almost like...			
M	Right			
P	...we have to maintain something here			
M	Mm			
P	We've never had a suicide in this college, not, not of a client who's being counselled, we have had a suicide in college...			
M	Yeah, you mentioned that			
P	...but not of a client...			
M	So it feels like what's being communicated by the organisation is basically 'suicide would be a failure of the service and of you as a counsellor...			
P	Absolutely			
P	Mm... and I think to some extent if something like that happened, there would be a lot of questions asked, so I think... naturally so I guess, but also... erm... I don't know whether there would be that same understanding and support for us as counsellors. D'you know what I mean? It would be, it would presume more of our failing, or why has that happened rather than a supportive atmosphere of 'well, if that was the student's choice, these things happen, better the student can choose	1	42, 20-27	Client suicide as a professional failure. Consequences of client suicide- professional and emotional

	that for themselves, regardless of what you've done			
P	I think, and you picked up on it, it's not upsetting, I think, but I think it does make me realise how much I do feel that responsibility, and something about the vulnerability of the students that I work with, erm, that 16-18, 16-19 bracket, where they don't have a lot of support…	1	43, 19-27	Perceived vulnerablity of young people. Feeling some responsibility for the suicidal client
M	Mm			
P	…so therefore I think I feel as though I carry more than if I was working with purely adults…			
P	Mm, mm… and yet, you know, yeah… so is it the different… or is it easier to manage that responsibility when it is an adult…? Is it easier to trust and kind of… erm… do you know what I'm saying…? Not feel that pressure and weight when it is somebody older	1	45, 4-29	Perceived vulnerablity of young people.Trusting the client, difficulty of
M	So is it in terms… well they're as an adult, they can deal with it better in some way…?			
P	Yes, yes…			
M	…or do I… almost feeling parental towards them in some ways…?			
P	That's right, I think that does… maybe at some level, but also I wonder if an adult has a greater support network as well, that makes it easier to kind of…			
M	So if they're older and more established they might have more people around them who might support them who might…			
P	…rather than…			
M	So not just the age and developmental stage they're at in psychological terms but actually an adult may have more of an established social network, family friends etc and therefore more support…			
P	Mmm			
P	Most… my experience is that most people when they are struggling with er, emotional, psychological issues and difficulties in their lives will be thinking about what is it like to be alive, 'what would it like to not be here' and I think that suicidal thoughts are quite a normal part of a human being's experience, it's kind of the option, and doesn't necessarily mean they're going to do anything with it, but I do think that 'I wish I wasn't here' can transpire into 'I wish I was dead' and often, on CORE forms, students and clients are recording themselves as at risk, even if they might not be, they are still having dialogue with themselves about wanting to be dead…	2	1, 35-44	Normality of suicidal ideation
P	We use CORE to assess er, when they come for the first session, so just before their first session, they'll fill in CORE, erm, the counsellors here and myself and the other two colleagues and trainees are aware that there… our policy, procedure here would be that if the student presents either verbally or with the CORE in any way describes suicidal ideation or intent that that would be, that would be rigorously assessed with the client in terms of what they mean by that, whether they have intentions, they've made plans, and if they have, that we would be acting to er… contact their GP, to enable them to be kept in a place where they don't commit suicide whilst we actually engage in the therapeutic work with them, so it would be, it would be, it would be a duty of care really to disclose or to encourage the student to disclose if they were actively intending… if they do have any suicidal ideation…	2	2, 12-24	Formal contracting
P	Yeah, this is just the way that we work within our team, in terms of the university, I don't think the university has any plans or procedures on erm, that I'm aware of anyway, in terms of what we should be doing. We work within the BACP ethical framework, which doesn't necessarily define that you have to break confidentiality, but what we do is we work very actively with the student, I think very rarely do counsellors actually break confidentiality without consent, generally what happens is the	2	2, 29-41	Working within own professional boundaries and ethical code

student will make an appointment or the appointment will be facilitated within the counselling session with the student's full consent. So I don't think to be fair, in the last eight years that I've been here, that, I think there might have been one occasion where consent was broken, because of risk. Usually the student is more than happy, the client's more than happy to… to go and speak to their GP			
P Although I don't really think generally, contacting their GP makes a huge difference, I think the counselling is where that change will happen, but there's something about making sure that we've covered ourselves and that we've made sure that students have got, that clients have got, as much support as they can have.	2	3, 5-9	Covering the counsellor/ organisation, getting support for the client, even if not effective
P Although I don't really think generally, contacting their GP makes a huge difference, I think the counselling is where that change will happen, but there's something about making sure that we've covered ourselves and that we've made sure that students have got, that clients have got, as much support as they can have, erm, and you were saying before about CORE, we don't use CORE as the risk assessment tool, we use it to inform our risk assessment in the session with the student, so CORE can sometimes… with a CORE form, a stu… a client will, can sometimes tick, erm, the risk questions as zero which means they're not a risk and yet the other questions will be very high, now that can sometimes suggest that they're actually just not disclosing that on the CORE form…	2	3, 5-15	Assessment, dialogic and continuous, client's 0-10 rating
P …so we do not use CORE as a risk assessment tool but if it's on CORE then we'll make sure that we address it. So what we use as risk assessment is dialogue… er, the CORE informs the dialogue	2	3, 19-21	Assessment, dialogic and continuous, client's 0-10 rating
P Absolutely, it's a dialogic tool, yeah, because I've worked with CORE for a long time, and I used to be on the steering committee for CORE, from very early on in the university I was working with CORE and what I've always said is that we must not use CORE as a risk assessment tool because if, quite often people will not tick the risk questions or they would underplay them, so look at the form as a whole and look at what the whole form is telling you, and if there's a mismatch, say I'm really I'm really aware that all of these questions, you've talked about how distressed you are, you've got unwanted thoughts and feelings all the time, and yet you're also saying that you've not had any thoughts around suicide? And sometimes they'll say, well I just didn't want to tick that on the form…	2	3, 26-37	Assessment, dialogic and continuous, client's 0-10 rating
P Yeah. I think… I guess it depends… individually we might have our own beliefs about people's right to choose and make decisions about their own lives, and about their own death as well, erm, but I think when you're working in a context… that isn't working as a sole therapist and you're working in an organisation, you need to be mindful of the organisational context as well, and in terms of the… the client's wellbeing is at the centre… but also we need to be mindful of… checking that we've done everything that we need to do for ourselves as well, I guess, in terms of how, what we believe, in terms of our own, erm… yeah, our kind of own way of working and our own beliefs as well	2	3, 49 - 4, 8	Conflicting policy demands
P …his life feels miserable and erm… and it's really difficult because whilst I empathise with that, I also want… have this dilemma, and debate going on within me which is that I want… also to manage and hold and contain with him whilst he perhaps looks at other options to see whether his life could be better and different, erm… so… M So it's accepting it but trying to sort of actually keep it in some way like you say, contained…? P Yeah, and managed… M While you're working with him, yeah… P …and to see if we can find a way to keep him in a place where he can be where he is with these feelings and not discount them and not say they're not valid, but to say… you know, are there possibilities in the way of this being able to change and, and… kind of managing and holding whilst he looks at other options and er, you know, I've actually worked with this person before three years ago when he was in a very, very similar place and he was able to get a good quality of life for a few years and so, you know, there's kind of that hope as well	2	4, 27-47	Holding the client, exploring options.

P So it is really in your mind when he goes away from sessions sometimes, 'I wonder will I see him next week?'	2	5, 1-2	Trusting the client, difficulty of. 'What if?' anxiety
P …and will he still be here…? Yeah… So yeah, I think for me, Mike, if somebody, somebody's life is so unbearable that they feel they do not wish to be alive, I don't have a right or a claim on their decision, however, as their counsellor/ psychotherapist, I would be saying to them, I would be saying that you know, ultimately it's your choice but you know my role here is to see if there's another option here and to… keep you in a place where you are not making that decision and you can perhaps find other options and other alternatives, 'cause that's what, 'cause that's what our role is, our role isn't to accompany someone to death, although I guess maybe it is sometimes…? Maybe it is…?	2	5, 6-15	Holding the client, exploring options. Suicide prevention.
P Yeah, I mean I think all the counsellors here, erm, who work with me, erm, work to the same kind of erm, in the same model, which is that we would always be… erm… trying to prevent… suicide and trying to make sure that there is, there is support and that the client has as much support as possible and it would be quite routine that we would say to them and we'd be checking with them that they had, so that that is, and my guess the organisation would be wanting that as well	2	5, 24-30	Suicide prevention.
P Yeah, I don't actually believe when erm, you know, when we refer a student to a GP, I don't believe that necessarily makes any difference to them. I think it makes a difference to us in terms of legislation and, and perhaps also, it makes a difference to counsellors in that they don't feel so alone…	2	5, 41-45	Covering the counsellor/ organisation, getting support for the client, even if not effective. Sharing or passing on the burden of responsibility
P …and I think it's a really really a very lonely place to be in a room with a person who you're working with, because we care about our clients M Mm P …and to feel that in some way that we're the only person who's holding or helping or being with that person in their distress, and even if we kind of just refer them to the GP and we feel that somebody else is there, maybe they're almost like a shadow for us, just to accompany us	2	5, 49 - 6, 7	Feeling some responsibility for the suicidal client. Sharing or passing on the burden of responsibility
P Yes. I think that you don't feel so isolated with it and that there is another agency that is checking up or seeing that person…	2	6, 20-21	Sharing or passing on the burden of responsibility
P We do a registration form which has just got basic generic information about them, their date of birth etc and their, you know, what course they're on and we also ask their GP… that's the other thing that we have done, er, in the last three years on the back of a suicidal client who did not have a GP and refused to go and see his GP, we changed our procedure here so that we ask all students, all clients give us the GP's details and consent to giving those details and we let them know that if we feel that they are at risk of suicide then we will be contacting their GP or first of all asking them if they will contact their GP or we will be contacting the GP on their behalf, so they're fully aware in the first session that that will be done	2	8, 14-24	Formal contracting. specific written contract
M …so it's actually specific and written, the circumstances under which you'd break confidentiality and how you'd go about that? P Yes, yeah, we talk about risk and we talk about risk of suicidal intent and er, we talk in the session- just going to see if I've got one here, I haven't, it's in the other office, and I can certainly show you one, you can have a copy, and we talk about the exceptions to confidentiality and it's on the sheet, on the leaflet that they get and it states what the exceptions would be, which would be suicidal intent, it would be erm, the… terrorism and also in that we put that in certain circumstances related to child protection there may be duty to disclose and so…	2	8, 39-49	specific written contract

P They do, and also what I'd say Mike, what I think is important that if you state to erm, the student that if they talk about suicidal intention and you're telling them that you're going to break confidentiality, they have a choice about whether they tell you or not, and I guess in that, you're giving them the autonomy to decide whether… erm… whether they wish to disclose it, it gives them the freedom to make their own choices I guess. What we're saying is, we're not saying that clients cannot engage in suicidal thinking or suicidal behaviour, what we're saying is if we know they are then we'll need to work with that…	2	9, 11-19	specific written contract
P Mm…. I think that suicide can be… something that people do when they are at their most despairing and that I understand why people commit suicide, I understand, I've had my own suicidal thoughts in my own life… M Yeah P …erm, and had days when things have been very difficult and I've wokren up and thought 'I wish I was dead'… erm, that doesn't mean that, clearly I've not acted on it 'cause I'm still here but there's a fine line between feeling like that and then other things impacting like alcohol, like, you know, an argument with a loved one, which can then trip someone into making that… decision, and I believe that… people should be enabled to be kept safe during that period, my personal feeling is during that period, because actually for many… erm… when you are working with suicidal clients, for many they come through that in, in kind of celebration of the fact they didn't act on it… and that's been verbalised in many sessions with students I've worked with in the past, where they've said 'I'm so pleased I didn't, erm and so I think that… my personal belief is… as well as my professional belief, is that people have a choice, absolutely have a choice about whether they live or die but that something about… just giving themselves a little bit of space to make sure it is the right decision for them and for it not to be something that comes out of impulse or comes out of a particularly difficult period	2	10, 7-29	Client autonomy. Rational/ Irrational suicide. Value of offering space to speak about suicidal thoughts
P I think if, if… I think quite often what happens is, somebody will make a decision, erm, that is informed by too many,,, erm compounding pressures… M Mm P …that, something about, yeah and they may be very chaotic at the time and they feel there is just no other option, erm, and I think that once you've kind of worked with the potential of options and what else they might be able to do, if they still believe that after all of that, then you know I kind of think well, do I have the right to decide for somebody else what they do? Quite often, I mean, this student I'm working with at the moment… because he's isolated and he is, he, you know, he hasn't got any family that he's in touch with, erm, he's living on his own at the moment, he doesn't have any people that he sees because he's so withdrawn and so basically he doesn't think that his death would matter to anybody…	2	11, 8-24	Rational/ irrational suicide
P …and so… he thinks that he can die and nobody will notice, and what I believe that our role is, is to sometimes challenge that, well actually, somebody will grieve, for example, I'll notice, you know, if that student goes away and commits suicide, I will, I will feel something about that, I will feel very sad about that and also, even though he's not in touch with his family at the moment, his family are going to notice, so something about helping people to be accountable as well… M So, so you feel part of your role in working with… with suicidal clients is in possibly challenging some of their beliefs and… which are leading them in that direction? P Yeah, and to kind of, to be congruent about, er, my own response, because the thing is, if they're in relationship, they might not be in relationships with other people but they've chosen to come into a relationship with me, and there's something about, you know… me being congruent about that relationship, you know, and I said, I said this to my client the other week, you know, I'm really hearing that you feel isolated and that you feel that nobody would notice, and what I need to say to you is that I would notice… If you didn't come back next week I would notice… and if you're not here and I hear that you've died, then I would feel something, I would feel sad. M Mm P And if I feel that and I've only worked with you for so many sessions, then my guess is that people who know you, who've been on the course with you, and people who are still trying to get in touch with you will feel that too. So it's something about not saying 'you're wrong', but it's saying… actually,	2	11, 28 - 12, 9	Congruent concern'.

this is how I'm experiencing it, it's helping people to take accountability I guess, for the decision they're making in an informed way			
P …so when you're working with that individual, the thing is that it's an 'I-Thou' relationship, it's counsellor and client and you know, the fact that they've got a husband, they've got a partner, they've got children, they've got pets or grandparents, that… it's not, we're not working with the system, we're working with the individual, but actually we are working with the system because every person is attached to a system and so… whilst… the 'I-Thou' is working with the client who's suicidal, we also are mindful of, and I'm mindful of, the other people around them and in their lives, and yet it's a real battle, because that's not who we're working with, d'you know what I mean, we're not working with…	2	12, 47 - 13, 6	Challenging with the ripple effect
P I don't think I feel, I don't feel at all responsible to the other people, but what I would say is I am aware of them, I am mindful of them, but they would not determine what I would do with a client	2	13, 29-31	Challenging with the ripple effect
P What I'm saying is, if a client bring… if a client brings a story and they open the page of the book and on the first page is them and you hear about them and you connect with that and then the next few pages you've got family members and other people, now we can't then not remember that those pages are there, so what I'm saying is that I don't feel responsible for those… 'cause I'm still with my client and ultimately my client is the one who would make the decision, but once they've brought those people into the room and they've shared that with them, they've become part of that person's story… and it is really hard to sometimes separate that off, but I don't feel responsible and I think if a client decided to commit suicide and I'd done what I'd felt what was right within the counselling with them I wouldn't feel it was my responsibility to have kept them… protected the other people	2	13, 35-47	Challenging with the ripple effect
P No, but what I would also do, I wouldn't be ignoring those people in the context of the dialogue, so when, if somebody's talked about somebody they really care about, you know, I really care about my children and I want to die and I feel I'm worried about how they might react, I would be reflecting that back and I would be bringing that into the… like my client who said that nobody would notice and he'd already told me that people care about him, so what I'm doing is I'm bringing that back into the room and saying I'm hearing you saying that nobody would notice and I'm also aware that in the last session you talked about a friend who keeps ringing you and saying 'how are you?' and I just offer that back to them	2	14, 10-19	Challenging with the ripple effect
P Yeah, holding them up I guess, it's kind of like saying 'you know, you've shown me these pages with all these different aspects of your life on and I'm just presenting them back to you, whilst you make the decision here, here are these factors that you've shared already, so you've got two sisters who at the moment you're not in touch with, but that you've talked about who've actually at times in your life have been supportive and you've got these friends and these are the aspects of your life that you've shared…' and then, that you just kind of…. hold them up… and I know a counsellor who, erm, erm, told me that what they sometimes do with suicidal clients and I don't know if you've heard this but what they do is if the client is suicidal, the place where they, say for example they would be inclined to take tablets and they keep them in a particular cupboard, this counsellor actually gets them to put photographs of significant people in that cupboard where the photographs, where the tablets are, you know, it's not something that I would do but, you know, I know that different people work creatively in different ways	2	15, 1-16	Challenging with the ripple effect
P …would work. I do sometimes ask them, if ask the student how they're thinking of committing suicide and what their thoughts would be, some would say, well you know I have so many tablets that are kept in the house and you know I will say to them, if you're wanting to work with keeping yourself safe, I wonder what it would be like to take away those tablets, take away that impulsive risk that's there, because I guess if you become distressed or have too much to drink, if those tablets are there it's going to make it very easy, or easier to actually maybe make an attempt, so you know, being aware that you've got tablets there and that could be a risk, what do you think about maybe thinking about removing those, that you don't have the immediacy and they'll sometimes say 'yeah, that's a really… I think I'll do that, I'll remove them' so I'll talk about as well, I'll explain to them how sometimes certain things can actually lead them to be more at risk and I've had clients who've actually done that, and they've removed things and removed ropes if they've had them in the house, so you know, I talk about how they can keep	2	15, 20-36	Practical risk management

themselves safe as well, whilst they make a decision			
M Ok. Erm… was suicide dealt with as an issue in your core training? P …we did have erm… we did have a session with Andrew Reeves in our, on our course, I think it was, I did my postgraduate at Chester, yeah, it's a long time ago, I'm certain we did cover it	2	16, 3-7	Vague memories of training
P …I don't think that the counselling training had any impact on my beliefs about suicide, I think that… I think probably what's had an impact on my beliefs about suicide has been working with clients… M Right P …and also knowing erm… knowing a family affected by a suicide	2	16, 12-18	Impact of own experience of suicide and of working with clients
P Yeah, I think my personal feelings about suicide, up until quite recently have always been that people have a choice and I understand distress, I understand human distress, I have my own life experiences that have taken me to a place where I have felt the most incredible distress and in my own research with bereaved mothers, there is a whole area in my research about suicidal thoughts to how when we're very, very distressed and in such acute pain, emotional pain, I guess also a physical pain with some people, we actually want a way out, and the only way we know of is death. We don't kind of have any other options, you know, so I've always felt that it is ult… I understand it and I don't judge it and I don't have any sense that it's wrong, personally, but more recently, Mike, I've known a young man, through my own family whose mother committed suicide two years ago, and I've seen the devastation of the family and also the fact that she was not contained, she asked to be contained, she asked to be helped and held during that period and she was released and she killed herself and there's something about would she still be here now if that had been managed differently and that's the bit that's kind of changed my view of it	2	16, 27-44	Impact of own experience of suicide and of working with clients
M So it feels like that's maybe made it more important for you to, perhaps be more proactive in the way you manage it? P Yeah, to be more proactive and just to get, to give people space and time but not to… disregard their feelings, 'cause I think the other thing that's really important is that in being proactive, you must not silence the suicidal thoughts, you must give space. Therapists must give space to those thoughts…	2	16, 46 - 17, 3	Value of offering space to speak about suicidal thoughts
P …because they almost need, clients almost need to go into the pit with those feelings to know what they're about to then choose to come out the other side, 'cause in a way… if they just walk around the edge of the suicidal thoughts, they're not going to be addressed and they're not going to make sense of why they feel like that and I think that's really important, so the two have got to be done hand in hand. There's the risk assessment, the risk management, but also enabling your client to really go to what these thoughts are about. D' you know what I mean…?	2	17, 7-14	Value of offering space to speak about suicidal thoughts
P No, not at all. I mean. I think I just realised as I was saying that, that I was talking so much about how you manage the risk that I hadn't really spoken about the therapeutic side of what we do, 'cause I think there's something about, if you've got the boundaries and the kind of erm… the risk management in place… to support the work, then to go into what those feelings are about is hugely beneficial, and you know, for example, I had a client when I worked for the NHS who spoke about, and I'll never forget it, he spoke about erm, being alone and lonely and how he wished he was dead and he said he imagined that nobody would ever notice and his description was 'until the maggots crawled from under the door'. Erm… and it was really important to go with that, to go with that dialogue and how this desperate, desperate isolation felt, how it was almost… to stay with that, 'cause that was where the therapeutic work was but at the same time holding the structure around the therapy to keep him from…	2	17, 32-50	Value of offering space to speak about suicidal thoughts

M Mm P …killing himself… and seeing if there's a time when the door could open and he could actually have a life where he connected			
M …what are your thoughts and feelings, when they first express those feelings? P …I think there's, for me, there's always a… a sinking feeling inside, 'this is going to be hard', yeah. Erm, in terms of the work, because, what I love to do, Mike, is I love to be in relationship with my clients and I love to be able to give them that space to be able to explore to be able to make changes, all of that…	2	18, 23-30	This is going to be hard work…
P …and it feels very, very, comfortable for me, and very enjoyable work. When somebody comes in with suicidal thoughts, the bits that I don't like is all the stuff that I don't like, the structure, risk management, I can't bear having to drill down, risk manage, look at what, you know, ask questions, check out what they've got in terms of support, all that stuff is, is, is taking away from the client having space to talk about it, so the bit that I dread is actually having to say 'well ok.. speak to your doctor and we'll look at this and we'll look at this and we'll look at this, erm…	2	18, 34-41	This is going to be hard work…
P …and them be the centre of the focus, you know, in a way, so there's a part of me that feels, erm, thinks about the kind of administration side of it and how I'm going to risk manage etc but the biggest part is that huge sense of erm… sadness, yeah, sadness that somebody's feeling like that	2	18, 46-50	This is going to be hard work… Empathic response.
P Yeah, you know, I feel sad, yeah… erm, hearing what it is that's taken them to where, where they're choosing or thinking to die… so the first word that, you know if somebody says 'I've thought about suicide', you know, 'I wish I was dead', my first feeling in response to that is one of empathy and one of 'God, this sounds really hard'	2	19, 5-9	Empathic response.
P …so depending on how they've said it, what they've said, what their words are, it would usually be about being empathic and giving an empathic response, it really feels so difficult, so if somebody said 'I've been thinking about suicide in the last… week or so and I wish I was dead, I can't bear what's happening in my life at the moment', it would be really about an empathic response it would be about an empathic response- 'this sounds really, really hard for you at the moment and it's almost unbearable for you and so unbearable that you wish you were dead', I've just given a very, very… erm… reciprocal and empathic response to it at first	2	20, 6-15	Empathic response.
P Yeah, I would be… there'd be like a little cog going round in my head at the same time, there'd be part… the main part of me would be in empathy and in being with the client in what they're feeling and at the back of my head, it's almost like another little machine's ticking off, tick tick tick, now make sure that you check the CORE form that you… risk assess, that you… I wonder erm, check that they've given their GP and, you know, there'd be that bit going on but I would be really careful not to act on that straight away… M Mm P …because, you know, I'd be thinking, you've got a fifty minute session and something about not silencing what they're telling you by getting this… machine in motion… M Yeah P …so really, really, it's so, so, it's such a finely tuned thing, normally you'd just be working with the empathy part M Yeah	2	20, 22 - 21, 2	The Swan'.

P But the risk management brings in this little machine that starts ticking away, it's a bit like this clock, ticking at the side, as soon as you notice it… M Yeah P …tick tick tick, there it is… and you want to pull yourself back into empathy…			
P Yeah, it takes you out of empathy and into the 'musts' and what I need and should and must do now… M Yeah P …so, there's, I think it's a skill that you develop or that I feel that I've developed over the years that I've worked as a counsellor, which I'm, it's probably about two thousand and… I don't know, nearly ten years, it's a skill I've developed where it's a bit like noticing it's your internal supervisor, it's like you're noticing the 'tick, tick, ticking'… and then acknowledging it and coming back into empathy but also knowing that you need to pay attention to that ticking at some point in the session…	2	21, 13-24	The Swan'.
P Yeah, yeah. I mean I think it's sort of… I mean, what you know it would be about saying to them that it would be perhaps useful for them to go and speak to their GP and their GP might also have a history of their… mental health…	2	22, 10-13	'Putting up the safety nets'.
P So yeah, it would be very active, I mean, say, but only twice, three times in the eight years I've been here have I needed to take anybody across to A&E and generally speaking they would be very comfortable to make an appointment. sometimes they'll ring from the room and make their own appointment. sometimes they'll say erm, can you make the appointment for me and I will. And sometimes I'll write to the GP as well, if I don't… feel that the student needs to be seen straight away but the student is making an appointment of their own free will to see their GP, I'll ask them would it be helpful for you if I write to your GP to give them an outline of what we've talked about today and they'll say yes, and I'll write a letter of consent to that and I'll then make sure that I've backed up the information so that when they go to the GP, the student has come and talked about feeling and wishing they were dead and having thoughts about suicide	2	23, 22-35	'Putting up the safety nets'.
P …and usually when they come and they're feel… and they're terrified of the feelings, er and if they really feel that they are actually so at risk that they're going to do something about it, they would generally want you to take them, they want to, the ones that I've worked with, they want to be stopped	2	24, 3-7	They want to be stopped.
P Yeah, and I think that's why, you know, when I said before, they have the choice about what they tell you and I think that's why they tell you quite often because they actually want, they want to help themselves through being helped, erm…	2	24, 22-25	They want to be stopped.
P …really care about them in the moment… care about them when I'm working with them, and some I feel a sense of love sometimes for the people I'm working with, you know, the big word, 'love', but I don't actually struggle with it outside. Now there are occasions when working with some clients who are suicidal, this one male I was talking about before, that… erm… you know, who talked about wanting to disappear and nobody would notice, that I will go away and think about them and erm, and I've had one student I worked with, one young student I worked with about erm… four/ five years ago and I can remember saying to him, can you just walk ahead a bit and I sat down and cried, erm, you know, very rarely has that happened, Mike, erm, you know, probably count it on, you know, two hands, maybe ten times in ten years where I've gone away and I've not been able to put that person out of my mind, I would not tell them that M Mm P …I would not tell them that I'd been thinking about them or that I'd cried… erm, but what I would do is I would transfer that into a dialogue that would feel therapeutic for them which might be something like '…and I really notice that I care and that it matters to me'	2	24, 42 - 25, 12	Feeling some responsibility. Congruent concern.

P	Yeah, and I think the other thing that I'd say is that sometimes when clients have talked about suicide and how they might commit suicide, I do have a, I do go into imaginal fantasy where I kind of have an image of hearing that the student has died		
M	Mm		
P	…or I have an image of them, you know, this one who said he wanted to crawl away, and he described how he wanted to crawl away just somewhere where he could pull, you know, leaves and branches over him and just wither, erm, 'cause he couldn't imagine himself doing anything active but he imagined that he'd just starve himself and I did have a very strong image of that in my head…		
M	Mm		
P	…it was a kind of vicarious trauma I guess…		
M	Yeah, I see what you mean…		
P	…and I kind of noticed that image and I've sometimes thought, you know, that I've imagined a phone call where I've heard that so-and-so's killed themselves, erm, but again, it doesn't last for too long, really, it's usually something that will come and then I'll notice it and I'll acknowledge it and then I'll say well, you know, that's quite a natural response to that…		
M	Mm		
P	…I guess. It doesn't dominate my life		
P	Oh absolutely, my supervisor's brilliant and she's very sharp as well with noticing and I am too, so if I'm talking about a client in supervision, if a feeling comes, I'll suddenly, I'll often say to my supervisor [….] will you just hold for a minute, I'm really aware something's here and she'll just give it some space, 'cause she's quite mindful, […], and just give it some space, and I'll say 'you know, I feel really sad, […]' and then… 'what's that about?'… 'I just… I've this image that this person might do something and I'm really scared', you know, I don't want that to happen, and yet also I know that it's their kind of choice, so I'll talk about the emotional impact, and if that happens in supervision, she's really good, what she'll do is stop the supervision session and let me… go with whatever it is with what I'm feeling, erm, and then look into the meanings of that, erm… and that's happened, you know, a few times with clients, and I think this is where the difficulties are for me, and I think probably for many therapists, is the fear of… the fear of a client… killing themselves	2	26, 11 - 27, 3	Have I done enough? They want to be stopped.
M	So what's that fear about? What's that fear of?		
P	Not having… perhaps not having done enough to give them a little bit more breathing space while they made a decision, you know, there's something about… informed, it being an informed decision, is there anything else I could have done that might have given them a little bit more time to see if things could have changed…		
M	Yeah, I see…		
P	…yeah, that's… you know, if, I imagine if I was working with somebody and they were working towards wishing to be dead and wanting to commit suicide and it being a choice that actually was… this is the choice I want to make, it might feel different, Mike, I think it might, but generally speaking, all the clients I've worked with have actually not been wanting to be dead, they've just been in crises…		
M	Mm		
P	…and that's the bit that I think makes it harder… the fear that you might not have enabled them to work through that crisis to a place where they decide is this actually what I want…		
M	Yeah		
P	…or is it a reaction to… pain and trauma and distress that might pass…		
M	…so it feels like that does then feel like that's, you feel responsible for holding that, managing that…		
P	Yeah, yeah		
M	…and getting them through that somehow?		
P	Yeah… hoping that my skills are enough to enable that… them to have that space, yeah		

Congruent concern'. A kind of vicarious trauma.

Am I good enough?

2	27, 9-17	

P …I think that the client has responsibility for their life… M Yeah P …and that the only responsibility I have… is in… my therapeutic skills to enable… that M Mm P So, in a way, erm… my responsibility is to be er, as good a therapist as I can be and to erm, but they're responsible for their lives	2	27, 45 - 28, 5	Client autonomy. Being a responsible professional.
M …How does that change when they say they're suicidal? P (laughs) …well I think there's an interesting kind of… er… what am I doing here, I'm moving my fingers around aren't I…? Erm… it starts to kind of fluctuate a bit then, where I start to have to kind of have a dialogue with myself about responsibility… M Yeah P It's still their responsibility and yet I start to feel that somehow I'm responsible for making my therapy tighter and… (laughs) …sharper and… you know, I think that I start to observe myself… doing… the therapy… normally I'm in there with my client, it's just being and experiencing and being a therapist quite naturally but I think I start to observe myself a bit more and I tighten myself up a bit more, so I do… I suppose I must do something different in my work… M So it feels like what you're having to perhaps work harder… P Yeah M …you feel 'I've got to put more effort into this'? P Yeah, definitely M …erm but also, it feels again like it's taking you out of that empathic connection in a way… P Yeah M …like you were saying about going down the checklist P Yeah, it can do but I think I do notice that. I begin to tighten up a little bit and to be, erm, to try and be, to try and check that I'm still covering everything that I need to cover… M Yeah P …which I ordinarily wouldn't do…	2	28, 11 - 28, 50	I've got to work harder. The Swan'.
P Yeah. And I think when I kind of think about the anxiety it feels very different to the anxiety I might get if I go and erm do something stressful like go and do a presentation. I've got a presentation to do on Monday that's been dumped on me today, I've got to go and do on boundaries with students. It's different anxiety to that, it's it is an existential anxiety, it's about the real sharp edge of what it is to be human, it's life or death, and I think that I imagine it's maybe similar to a surgeon who's working on somebody who finds that the critical moment happens in the surgery where at any moment this client, this patient might die… M Mm P …and I imagine there's a bit of an adrenalin increase, my sense is it's a bit like that, Mike, it feels like an existential adrenaline increased, anxiety that comes out of life and death	2	29, 12-26	Initial panic/ anxiety. Life and death, finality.
P …mm. I think that where they bring it into the room with you and they share it with you, there is a sense of responsibility because they've brought it in there… and I can't just say, 'ok, so you're suicidal and you're feeling like that, this is your world, guess it's your, you know…'	2	29, 45-48	Feeling some responsibility for the suicidal client
P …I don't know… I don't know if it's a different feeling, I just know that… I know that I react differently and I don't know if that's around, if I was to unpick it, I don't know if that's around the sense that I have of responsibility to the University, if something was to happen here, I wonder if I'd be feeling different if it was a private practitioner…? It's difficult to unpick it when you're in a context… you know what I mean?	2	30, 10-15	Consequences of client suicide- professional and emotional

P …and she said 'I can't work with you if you're dead'… And it's a really good point, sounds like it's stating the bleeding obvious but actually… there's something about, you know, we can only work with our clients if they're here to work with them, and so it feels like my role as a counsellor would be in terms of being with them… Erm… if they… they need to stay alive to do that, but also as a human being… it's quite frightening to think that somebody might leave your room and end their life… M Mmm P Mm M So it's the potential consequences seem to raise the stakes…? P Yeah, and the ricochet of that in terms of anything else they've shared with you about their life that you then know… as in their family, their friends… M …and so it's that, the wider impact again… P Yeah	2	30, 35 - 31, 7	Value of offering space to speak about suicidal thoughts. Suicide prevention. Challenging with the ripple effect
P I had a, that came on the back of a student I had, I think I mentioned to you, he didn't give me his GP because he refused to have a GP, he said 'there's no point having a GP, so every time I've gone to a GP over the last twenty years', it was a man in his mid sixties and he said 'they've done nothing to help me in fact if anything they've just medicated me'. So I was in a position as a counsellor where I didn't actually have a fallback, I didn't have the NHS to go to, I didn't have a Doctor, I had this suicidal client whose plan was to put himself on a railway line and be hit by a train, which is quite a common way… M Yeah P …but actually what he said was, because I couldn't refer him and 'cause I couldn't send him to his Doctor, and we just worked with, I just enabled him… I just went into empathy, well there's nothing I can do, I can just be the counsellor for him and he said to me, for the first time in his sixty five years and he's had loads of psychotherapy, loads of psychiatry, it was the first time he'd actually been able to go into the pit… and talk about it M So almost because you had nowhere else to go with it but to work with what was… P Yes M …and that almost felt… more effective in some ways or, it was effective because of that? P He said that it was the first time he went into it without being prevented to through drugs or through treatment and he then said that he was able to go into it, know it and come out of it. And he said it was the first time he actually felt that he didn't want to die… because he'd gone into exploring what that was about… M Which goes back to what you were saying before about the importance of them being able to do that… P Yes. And for the actually intervention that you erm, apply, not to… dominate or change… the therapeutic… M Yeah… P …relationship M …so it's the importance of actually keeping that therapeutic process there, whatever else you feel… you have to do, either for you or the organisation…	2	31, 29 - 32, 25	Value of offering space to speak about suicidal thoughts. Client autonomy.
P …he's still in my mind and he's still part of how I work with suicidal clients because he taught me that whilst it is important I think it is generally important that we do have the Doctor's support that we need to ensure that our role as counsellors and psychotherapists is in being with the client in making sense of the meaning behind the desire to die	2	32, 41-45	Value of offering space to speak about suicidal thoughts
P Erm… I don't know, I mean, I'm very erm, I'm a very congruent, honest, (laughs), open person, I don't, I don't er… I wonder whether people dare to say how they feel about things sometimes, I think it's the sharp edge of the work we do and I just sometimes wonder whether other counsellors would be as open about how vulnerable they feel sometimes, I don't know how sad they feel…	2	33, 9-14	I've given honest responses, would others?

P …or feel panicky, erm, or think 'Oh my God, no, a suicidal client', yeah, this is going to take loads of paperwork. It, you know, I don't mean, that sounded really flippant that, as though the paperwork's the bit, but what I mean is that that's part of it all, the main thing is, 'this is a suicidal client and this is really hard… for them'… M Yeah P …'and hard for me to hear this too'	2	33, 23-31	This is going to be hard work… Empathic response.
P Yeah, and I've not yet had a suicide and I have that sense that one day I may, erm, and the university's not had a suicide while I've worked here and a part of me feels really pleased about that, and I suppose my gut feeling is I don't want to have a client commit suicide M …It's almost like a sort of… we've got to kind of keep this 100% record, that sounds a flippant way of putting it but… P But you know, you know, just… I guess it's about not wanting somebody to die… erm…	2	33, 44 - 34, 3	Suicide prevention. Client suicide as a professional failure
M So do you actually have any sort of, or does the college give you then in that case, under those safeguarding rules any guidance on how, you know, how you have to deal with issues around suicide… P They don't give the counselling team any guidance…	3	2, 4-8	Working within own professional boundaries and ethical code
P They would have policies there for… very generic but not specific around suicide, it would come under child protection issues or vulnerable adults	3	2, 12-13	organisational safeguarding policy
M Yeah… So does that then leave you kind of as a counselling service kind of, you're deciding what your boundaries are on that and how to work with them…? P Yeah, I would begin with my professional body, BACP and their professional guidelines and working within that, so some of that can be in conflict with what a college policy might say around confidentiality… M Yeah P …but, professionally I suppose I'm fortunate in this organisation that they respect that autonomy and that professionalism about that…	3	2, 24-35	Working within own professional boundaries and ethical code. Justifying working to BACP guidelines instead of organisational policy. Conflicting policy demands.
M Yeah, so it would be more you're being employed in this professional capacity in you're to an extent allowed to be able to work within your professional… P Yeah M …erm professional boundaries determined by your professional organisation? P Yeah… I would. Although saying that, I would if I was here, obviously if somebody was and I'd had that assessment that they were suicidal, I would be putting things in place or putting referrals in place, so there's no policy saying I have to do that but I would be doing that within this organisation	3	2, 43 - 3, 6	Working within own professional boundaries and ethical code
P …so that type of referral tends to come from her if it's, if somebody's disclosed. The assessment side… erm, I suppose for a number of years, I suppose I have studied this particular area, you know, over the years, obviously I've not genned up for this type of interview, so I'm quite… erm… I'm quite familiar with the risks and what mental health teams use, but I don't use those, although I'm aware of them. So my risk assessment isn't a paper exercise, it's er, it's more based on my experience and of where I've worked with clients, my experience of how I'd assess somebody's risk- depending on what I'm bringing and what's going on for them and looking at that referral system. I tend not, I wouldn't say to- I wouldn't use the word 'assess' in a formal way to other people, like I've assessed you and you're not at risk or you are… M Mm	3	3, 43 - 4, 11	Working within own professional boundaries and ethical code. Assessment, dialogic and continuous, client's 0-10 rating

P …but I would make a professional judgement- does this person need extra services and the majority of the time it would be yes, I'd expect more than to go to the GP to be formally assessed… if that makes sense?			
P I'm not, no, I'm not using any paper based system and I'm quite pleased that I don't have to do that…	3	4, 19-20	Assessment, dialogic and continuous, client's 0-10 rating
P …'cause er, for a number of reasons. If I was going to do a very er, something that could be useful to work with and give me a bit more of a guideline I might use a scale of 0 – 10…	3	4, 24-26	Assessment, dialogic and continuous, client's 0-10 rating
P Well, my assessment would start the minute they come in, 'cause I'll be asking where they live and what course they're doing and things start flagging up, so if they're homeless, that's going to be a massive warning signal to me, or if there's been a pattern of abuse, you know. So there's certain things I'll ask them when they first come, and I don't ask a lot of questions but even just about their life at college and how things are going, you know, if somebody's just started at college how did they get on at school, if they've had counselling before how was that, so I'm building a picture up before they've actually started	3	5, 1-9	Assessment, dialogic and continuous, client's 0-10 rating
P Yeah, both. I verbally do it and then they have a written one that I'll go through as well. So, I think its… I think you'd recognise it fairly standard but it sets out, you know, who, who… what the counselling service is, confidentiality and the exceptions where it would be broken and there we would put harm to self or harm to others and I always say when it's harm to self that's if they're suicidal, I would use the word… M So you do actually make that specific? P …on the contracting, yes, if they're suicidal or intend or got the intention of suicide, I might, I would have to breach that and then I would explain who I might have to breach that to	3	5, 46 - 6, 8	specific written contract. Formal contracting
P So I might say… for self harm as well, you know, that if you're cutting, I don't, 'cause you know, you get a lot of young people are cutting… M Yeah P …and I actually explicitly mention that if I wouldn't have to breach it because of that	3	6, 25-31	Being specific about self harm
M Right, so it's actually the wording 'suicidal intent', yeah… ok P We used to just have it as suicidal but I think we put the intent in to cover… M Mm… so that's more a sort of a… perhaps a more… wouldn't necessarily cover ideation or thinking of it but it's more a serious… you know, a plan or something like that? P Well, I think that was a, following a discussion with the other counsellor that's what we came and wanted to do, 'cause we work with a lot of people who say that they're suicidal and they, they are actually… they're actually just having a bad day! (laughs) d'you know what I'm saying? So it's… it's what word to use really M Yeah P I would've just probably had suicidal but in agreement with the other counsellor we decided to go with suicidal intent, that they intend to do something M So its… so that's quite specific then? P I would work if somebody was planning or intending would feel very different than somebody just having that first disclosure and using that term, you know	3	7, 7-32	specific written contract

P …there's a lot to it and I'm quite happy to share… I think it's quite, I think the term is what I struggle with… M Yeah P …and what that means, 'cause I think it means so many different things to so many different people, 'cause I know personally in my life I've had times when I've had that thought 'I might not want to be here'…	3	7, 47 - 8, 4	Rational/ irrational suicide
P …and I think that sort of, the majority of the time plays out with young people, it's not that they want to die, they're just struggling to live M Mm P …you know, but yet people will label it that they're suicidal… M Mm P …and in actual fact they may be depressed or it might be a normal reaction to what they're having to deal with…	3	8, 13-23	Normality of suicidal ideation
P …and a lot of… my beliefs… I think… I think for me, it… professionally and even personally it feels important to allow somebody to express if they're suicidal without a complete overreaction so they can actually explore it… M Yeah P …and I've found with young people, if they've accessed other services they've not been allowed to talk about being suicidal… M Right P …or they've not been allowed to, they've got to stay positive, where I will allow them that space to be where they're at… M Yeah P …without judging them on it, maybe helping them to make sense of it M Then it sounds like you feel that's very much important in terms of the role that counselling can er, provide in working with people who may be suicidal? P Well, quite a lot of the young people who use that term would realise that it's part of a grieving process or it's part of a reaction, that they're not actually be doing anything. The majority will reassure you, er, but. you know, they're not high risk. but they need to be able to have a voice and vent it and I think counselling. you know has a fantastic place to be able to create that safe space where they can actually say that, so I think in my life when I have felt that down, there's very few people I could share that with in a way that would be helpful or useful	3	8, 34 - 9, 14	Value of offering space to speak about suicidal thoughts
P So it feels quite er, that's why I think it's important when I'm contracting to use the word, to show that I'm not afraid to use the word, I'm not afraid to work with it. But saying that I've worked with a couple of clients you know, that I would say are very, very high risk	3	9, 18-21	Formal contracting. Not avoiding the term, being specific.
P …you know and erm needed a lot of services and backup but they still could come and work with how bad they were feeling and where people have attempted to take their own life and been discharged and come to college the next day… you know, so I don't know, I suppose a lot of my values are clouded a little bit with some of my client's experiences when they've been through the system, when they've been through hospital or been through mental health services erm and I can get really frustrated about the lack of resources or lack of understanding that they experience and I feel that sometimes I, I'm offering something they're not getting through, you know, the statutory sort of system…	3	9, 25-34	Value of offering space to speak about suicidal thoughts

P So in that sense… I know that, there's something about respecting where somebody's at… Er, I think what it can leave behind… and the… I don't know, what the word would be… carnage behind can be quite… traumatising for a lot of people M So you're kind of quite aware of the effects that this person's death may have on the other people around them? P Yeah, yeah… and yeah, I've had, I wasn't a client but we have had, you know… clients… students who have taken their lives at an early age… M Yeah P …d'you know what I mean, that ripple effect that's gone through, the friends, the college, the family, you know, it's, it's lifelong stuff what it can leave behind M So you can look at it as an issue that it's not only about this client, there is a much wider effect that that suicide could have? P I mean I wouldn't load that on the client, you know, but…	3	10, 7-27	Challenging with the ripple effect
P Yeah, and I've had a family member that killed herself, I was quite young at the time but I guess you know, that's probably had some impact on how I see it and how I deal with suicide M You've seen the effects that it can have on other people… P Yeah M …it feels like that therefore sort of affects how you might see… a person expressing those… P No, I don't, 'cause I don't particularly have that then and I certainly wouldn't convey it but I can't sort of say that it's not around… when I'm with that person that's suicidal, that's not where I'm at…	3	10, 45 - 11, 8	Challenging with the ripple effect. Impact of own experience of suicide and of working with clients
P I think for me, I think… the number of people I work with who are suicidal and the number that I think are very risk, I think with those that are very high risk it probably does come in M Mm P …because I think that it could happen, you know what I mean? M Mm P That eventuality that they might make that decision and I suppose it's just being aware that that's going to have a massive ripple effect… it would have an effect on me if one of my clients killed themselves…	3	11, 22-34	Challenging with the ripple effect
P …in a way it's only a matter of time till that could happen and it will happen, you know, and how that would affect me, that would have a massive effect on me… but that wouldn't… but I don't think it would block when I was working with them, you know, in allowing them to be where they are… I think sometimes it can feel slightly different when you're working with somebody who's very young who's suicidal… M Right, in what way, what would be different about it? P I think usually in the sense, they're very confused or they don't understand or their childhood and the background to that and put the right resources in and they can turn it around and… I don't know, the impact would be as big as if it was somebody that's older… I don't know, just something feels different, feels quite… I suppose it feels quite… they're developing who they are and an adult might have more of a sense of who they were to make that decision… does that make sense? M So I guess if I'm trying to kind of paraphrase, you perhaps feel that they're at a stage in their life where they're not as able to make let's say a rational decision around whether to end their life maybe… have they actually got that capacity to do that? P Possibly, 'cause sometimes they could be like that one week and then the next they might be, you know, it's gone… d'you know what I mean? It can be quite transient as well, you know and I know when I've worked with young people who have attempted it, you know, that… how difficult it is afterwards… M Right P …and sometimes how glad they are, you know, or, you know, they hadn't really thought it through… trying to think, maybe it's 'cause I've worked with mainly young people. I've worked with some adults that are suicidal but probably not as many M It feels like for you it feels more when there's a higher risk but also when	3	11, 38 - 12, 33	Perceived vulnerablity of young people

they're young, it's that seems to have more of an impact on you?			
P Yeah, I suppose it's around them knowing who they are and their autonomy, they're still evolving and they're still developing			
M So you're saying that… I don't know, perhaps an older adult would… would be more autonomous than a young adult?			
P I know it's a generalised statement but.. perhaps on more occasions, I don't know… yeah…			
M Ok. Was suicide covered in your training as an issue, as a separate sort of topic?	3	12, 35 - 13, 2	Vague memories of training
P Erm, I think it was but it was quite a long time ago…			
M Yeah			
P …I've studied it a lot 'cause I worked in a college of nursing, teaching nurses counselling, so I would have been delivering sessions on it			
M Right			
P At one time I worked with a mental health nurse who was a tutor, delivering sessions on suicide but that was more to mental health nurses, so I can't remember exactly my training, I think it will have been because of that type of environment, you know, that it was nurse orientated			
P …but no, I think we did, I remember some of the exercises we did… erm and I think any of the training your counselling gives you that view if you've not been in that situation, if you've not been through it, to try and understand what it might be like… so I'm sure that er… you know, it will have been covered and it will have had an impact. I think that for me the biggest learning was when I was supervising somebody who was working with an adult who was suicidal and… at the time wasn't breaching it and the person was refusing to get help and I was working within that… what we could do to support that counsellor in not having to disclose it, so that was quite massive 'cause it was really respecting that client's autonomy that that's where they wanted to be at… but it's scary, it was scary stuff as well. Eventually we had to, you know, we had to access help for her, we had to breach confidentiality but we did it with her permission, the counsellor did…	3	13, 17, 37	Value of training in recognising we can't know how others feel. The grey area. Client autonomy. Holding the client, exploring options.
M Yeah			
P …but I remember for quite a long period of time, erm, you know, I remember it wasn't me directly but as a supervisor, supporting and allowing somebody to really respect that autonomy of this client… but how challenging that was, you know, it felt quite risky…			
P …erm… I'm trying to think, the time I was doing my training I was also doing some work around HIV as well and it's probably more linked to that, at that level of shifting my understanding or experiences or perception of people's lives and how desperate they might get	3	13, 48, 14, 7	Hard to empathise with suicidal feelings if you've never had them. Value of training in recognising we can't know how others feel
M So somebody going through an experience that's very different to something that I might have been through?			
P Yeah, yeah… yeah			
P I don't know, I suppose it's just an understanding and… I suppose just giving you just more of an empathy really, I think I had it quite there anyway, d'you know what I mean? I've not had a massive 'oh wow, suicide is about this' and 'what would it be like' and 'I've never felt like it', you know, because I've not been in that extremes…	3	14, 12-16	Hard to empathise with suicidal feelings if you've never had them. Empathic response.
P …I'm not, I've not been too afraid of it. But I'm also aware because of my nursing background, you know, sometimes you know, you had to have that professional façade and I've dealt with a lot, I've seen a lot, so it takes quite a lot to shock me, d'you know what I'm saying, it's not that I've come into counselling and I've just had my own world, but because I've been exposed to such a lot of… er, tragedies in people's lives…	3	14, 20-31	The Swan'.
M Yeah			

M Yeah P …I'm not fazed by it and if anything, doing counselling I've had to become more in touch with how it does impact on me and try to get more sensitised to it…			
P I think that when I was training that was there, I think it, you know, the feeling side of it is more there now, but sometimes if my workload's very heavy I can almost feel that desensitisation coming back where I'm not feeling everything, or, 'cause I don't want to feel everything, I don't want to be traumatised by what I'm being exposed to… M Yeah, yeah P So it's almost took a flipside really, with experience and time about vicarious trauma and me looking after me. it's a bit of the other way, not being fully in touch with how things affect me emotionally to then going through all my journey and being able to be more transparent to now learning to be a bit more protective and not feel everything. to look afer me as a therapist	3	14, 43, 15, 6	The Swan'. A kind of vicarious trauma.
P Well usually… it's very unusual that I'd be surprised at that, so I usually will have picked something up within what they've said… M Right, so its… P …or how they've said it… M …not going to have a big 'Ooh' sort of thing for you? P No, it's unusual… M Right P I'm not saying it never does but it's unusual	3	15, 20-33	The Swan'.
P Some do… erm… I think there's, I don't know, there's probably a couple of things that go on. I think what the client probably experiences is me being fairly calm about it… but very… erm… we need to talk about this and address it and look at it. I wouldn't use the word 'assess' but look at what's going on, what that's about… but I think for me I'm very empathic… M Mm P …erm, and that tends to get all my information that I might need if I have to take any action, and I think because I tend not to have this big (sharp intake of breath) reaction on a lot of things…	3	15, 42 - 16, 3	The Swan'.
P …that, you know, I'm aware that sometimes I can be probably too chilled out about it (laughs) but very… I can… counselling-wise I go into a bit of a different mode, 'cause I do need to put things in motion if there's a plan or an intention there, what services are they getting already, have they been to their GP, will they go to the GP… and that's, that's part of being of a professional counsellor, but I'm coming out of… really working with… d'you know what I mean, I'm doing an assessment as into… I'm a counsellor within a college and I'm limited to what I can do to get, to work with them, 'cause I don't work full time…	3	16, 11-19	The Swan'.
P …so I would be just looking at what resources I can link them up to or get them in touch with so they can get the help, if I have to, you know… I'm trying to think, it wasn't at this college, it was at another college, you know, I ended up having to get to casualty and I know that's happened here a few times with… you then… you know, and that involves a different feel for a counsellor, that's quite hard to be part of that process…	3	16, 27-33	Uncomfortable as a counsellor dealing with practical risk management.
P Yeah, yeah… I think that sort of sums up, not on every- 'cause every case is very different isn't it, but I think if I was trying to reflect on my practice and how I do react and the impact, er, I probably erm… I'm very calm but very efficient in the sense of looking at what needs to be put in place, so then I can- even if it's to still work with them… erm… to be honest, the majority of the time, I don't have this massive reaction because I know that one, they'd see it and two, they're going to be ok	3	17, 16-22	The Swan'.
P But you know, there are clients I've worked with… maybe it might only be two or three in a year when I'm worried, I'm seriously worried about them because of what they're presenting with, 'cause the… for me it might be some. you know, mental health disorder that's going on that they need treatment and attention very quickly. That feels very different when I'm working with that client because I'm alerted that this person is a high risk and if they're not getting the services that they need or they're	3	17, 26 - 18, 8	The Swan'.

	out in college and you know, they're struggling, I need to know if they come in the next day, so normally I would chase the client up the next day but if someone was in that category I would… I would want to know if they were in or if they left college or, usually then it would come under safeguarding, there'd be another team within college that would be alerted around that… That feels very different than somebody who just says that they're just suicidal… M Right P …to be honest my experience is it's the ones who are not saying it (laughs) that could be at high risk, and the ones that I'm probably most concerned may not use that word but are showing symptoms M Yeah P They might not say 'I'm suicidal' but they might say 'I found myself on a bridge out of the blue and without any warning and I wanted to jump' M Yeah P D'you know what I'm saying, that feels very different… M A more sort of impulsive kind of thing possibly…? P Yeah, yeah			
	P Yeah. I'm not saying I necessarily always feel that but… er, I… there's two parts, I feel sad that they're in that, that that's happening in their lives but another part I'm really pleased that they've told me M Right P I'm really, I feel quite honoured M Yeah P That they've been able to name it, even if they don't use the word 'suicide' whatever they've said I feel real honouring that they are either trusting me or they're desperate (laughs) but the fact that they've said it, I think is a massive sort of healing or hopefully potential to get some help and for this to change for them	3	18, 16-30	Glad they've shared suicidal feelings. Empathic response.
	P A real, you know, I feel… that they've trusted enough to be able to disclose that, I think it's quite massive really, yeah	3	18, 44-45	Glad they've shared suicidal feelings.
	P Well, it's a good feeling that they've trusted me to tell me, erm… I still think it's quite a stressful sort of issue then, you know, I think… I think 'cause I'm aware of the organisation I'm in as well and what the purpose is, you know and there's that dichotomy of I can offer therapeutic help and support… M Yeah P …but often they might be accessing umpteen services elsewhere and it's trying to negotiate where I am within that, who's doing what and who's not and trying to get the right thing for that person…; sorry, I forgot the question there	3	19, 1-12	Glad they've shared suicidal feelings. Other support involved can make the situation complex.
	P Yeah… some things I just need to clarify and they might just say, 'oh no, I'm not suicidal now, it was at the weekend' and you know… M Yeah P …you know, you're just moving on and it's not a, it's there, it's flagged up and I might have to, it depends what they've said, I might choose to tell my line manager and just flag it up for the safeguarding issue M Mm P Whereas somebody who's come in that I'm really worried about, that could take a whole day to sort out…	3	19, 19-31	This is going to be hard work…
	P … I wouldn't put myself up there that I'd assessed them in the sense of what I'm qualified to do, my judgement, my professional judgement. Both of the counsellors here, myself and the other one, you know, we don't want to get into that paperwork, 'cause I know quite a number of my suicidal clients have been through the system and have been asked these reams of paperwork, reams and reams and reams, and they've found that actually more traumatising and more off-putting and they	3	20, 4-20	Value of offering space to speak about suicidal thoughts. Working within own professional boundaries and ethical code

won't go back and get the help. I'm fortunate I don't have to…

M Yeah

P …I'm pleased I don't have to… have all the erm… standard suicide assessment forms that a lot of counsellors have to…

M Yeah

P I'm glad that I can use my professional judgement round that

P Yeah, I don't want a tool… Yeah. If I did, the tool would be to cover my back M Right P That's would the tool would serve a purpose, rather than assessing a person it would be to cover my back if, you know, if I had to be accountable	3	20, 25-32	Covering the counsellor/ organisation, getting support for the client, even if not effective
P …and there's some… you know I have to really trust in that young person if they're going to take their life or if they're not… and that's, that is a challenge and I do it and I've had to learn to… to some degree to detach… from it, 'cause if I took it all on board I wouldn't be able to do the job I did	3	21, 14-18	Trusting the client, difficulty of. A kind of vicarious trauma.
P Young people you might have one or two shots at it and you've gone… M Mm P …we don't chase them up, we don't follow them up, you know, there's a real lot of counsellors who go through this sort of process, they find it really challenging because you don't get that feedback, you don't get that long term stuff, knowing that what you're doing's good or you've made a difference… M Some kind of closure I guess I'm thinking…? P Yeah, very rare, very rare, there's a real trusting in that person's autonomy	3	21, 29-41	Trusting the client, difficulty of.
P I might put them in a soft way but I don't skirt round the edges if you know what I mean, I want to know, you know, say some… young lad was suicidal and when he came back I'd be asking him how is he, has he been to see the CPN, has he had any, you know, suicidal thoughts, you know, I'll do that at the beginning because I'll need to before I can do the therapeutic work with him	3	22, 14-19	Not avoiding the term, being specific.
P …'cause my training was person-centred originally but erm I feel fairly confident in… I'm not afraid to use the word, I'd rather have it out and let's talk about it and work with it…	3	22, 28-30	Not avoiding the term, being specific.
P …and it's important for me and I think it's important [for] them, 'cause you're in a way, I don't know, I think it can be a very secret thought or a secret idea that somebody may never share with, not all the time but the majority of clients aren't really telling people how they're feeling till they come to me. So I think it can be quite liberating for them to be able to talk about it… M And you said earlier that you feel it's important for you to be able to give that to them… P Yeah M …that they couldn't get in other mental health services… P Yeah, I don't really like to make that judgement but my experience has been very negative of what I've heard, very negative. Which puts more pressure on me then, because it feels like I'm probably the main key person that may be keeping that person going and keeping them alive M Mm, that feels like that could be quite a burden almost… P It is a, it is a, well… M Is that the right word? P It's a weight, yeah, you could use bur- it's a weight, a responsibility, erm, you know and sometimes that happens…	3	22, 42 - 23, 18	Value of offering space to speak about suicidal thoughts. Feeling some responsibility for the suicidal client

P Yeah, yeah… yeah. I mean I have good supervision and here I have a brilliant relationship with the other counsellor and we supervise each other, I've got a supportive manager, I've got everything in place… to get that help that I need but the load of it, especially if you've two or three or you've had a week where there's quite a number of- sometimes it's not just round suicide, it's child protection issues that are heavy as well…	3	23, 22-27	Feeling some responsibility for the suicidal client
P I don't feel that at the time, I'm glad they have shared it but it's… as a counsellor it feels different… than those two extremes that gave you, somebody who's not told anybody then shared it, to somebody who's spilling it out, it doesn't mean I'm judging them any different but it does feel different…	3	24, 16-20	Other support involved can make the situation complex. Sharing or passing on the burden of responsibility
P I suppose if I thought about the person that's disclosing out a lot, usually, I think because it takes quite a lot of energy to keep a handle of who's been involved, who knows what, who needs to know… M Yeah P …trying to educate the clients into… knowing what they need to do. The majority of the time they don't intend to take their life but you never know… D'you know what I mean, it's that, do they cry it so much that when the one time when someone should take notice they don't 'cause they're always… It just feels different, more complex to some degree, yeah	3	24, 24-35	Other support involved can make the situation complex.
P …to be clear on exactly the differences but it does, there is a different feel, I think around how to manage that within an organisation… erm… you know, 'cause it has a wider impact really	3	24, 46-48	Other support involved can make the situation complex.
P Yeah, and difficult to assess, 'cause they might be seeing people in the community who aren't linking up with me… M Sure P …or don't want to link up or the communication isn't there, that's more the frustration, maybe the difference is it's more frustrating. And I think round the disclosure, if I had to tell my line manager, because it would come under child protection and safeguarding, the majority of the time I think because of my experience I'm telling her that I'm working with this client, they're suicidal and this is what we've put in place and they're going to be coming back, you know very rarely does she have to say 'well we need to do A, B and C' but I think that's more because of my experience, you know, I'm not going to her for her then to tell me what to do, the majority of the time I've actually acted on it or they're going to go to the GP or I've got to get an ambulance and get them to A and E, usually I've already I suppose assessing it and identifying it and putting things in place… But I would still have to notify my line manager if I was working with somebody where I thought there was that risk	3	25, 15-33	Other support involved can make the situation complex.
P Yeah, so, you know, I know through experience if a young person has been in hospital and is linked up with a crisis intervention team… that what they feed back to me is the crisis intervention team will make contact with them once a day but they're not necessarily in therapeutic intensive support, d'you know what I mean, so it's like, it's trying to work, trying to know how safe is that person when they're leaving college and do they know how to access services and if they do are they going to get the support? I've not heard good stuff so it doesn't give me confidence… If I knew everything was in place that would give me confidence out of hours but it doesn't, it doesn't happen…	3	25, 47 - 26, 6	Value of offering space to speak about suicidal thoughts
P Sometimes if, sometimes there's a good GP and that's fine. When they've got good support, that's brilliant but if they haven't, especially somebody young that's homeless or they've not family support… you know, and then they're not getting that through the GP or mental health services, yeah, I do, I mean it really hacks me off but it does give that weight and that responsibility that I have to carry	3	26, 19-24	Feeling some responsibility for the suicidal client
P I suppose I'm not going to communicate that sense of… responsibility, you know, I don't want to burden them and I don't want them to do just 'cause I want to cover my back, erm… I think, you know, more recently I think I'm more aware that I need to be professional and cover my back, but I wouldn't be putting that onto the client but I do have that responsibility, you know	3	27, 13-18	Feeling some responsibility for the suicidal client. Covering the counsellor/ organisation, getting support for the client, even if not effective

P …and you've got to carry that, everything's kicking off the week before Christmas, you might have told them about all these other services but I don't have confidence in all of them… M Sure P …so that I would be carrying all of that… It wasn't at this college it was somewhere else, you know. I had to really be open about that and it was quite heart wrenching stuff really…	3	27, 31-39	Feeling some responsibility for the suicidal client.
P …to aband- it felt like I was abandoning that person… M Right P …over that period of time and she was very suicidal, she was very, very suicidal and er… I nearly packed in counselling, I nearly- M Yeah? P I contemplated it, I didn't nearly, I contemplated it, can I really be in this because… you know… I'd have done anything to be able to say 'you can come to mine for Christmas' M Yeah P …wouldn't be appropriate, it's not professional, I didn't do it, but on a human level… M That's what you felt you wanted to… P …this kid had nobody… M Yeah	3	27, 43 - 28, 15	Feeling some responsibility for the suicidal client. 'The emotional contract' - betraying this. Wanting to do more.
P I don't know, it's hard to measure that… erm… on a head level I'd like to think I've got my head round it's their responsibility (smiling) … On a human emotional level… I think with certain maybe clients, certain times of year like that… erm… I can have… I feel that responsibility, I have done, there's been pockets of times when it's been overwhelming but as I say, it wasn't in this organisation, it was another organisation where I wasn't being backed up, I wasn't supported, you know, there was a lot of other things in place that made that… weight heavier	3	28, 34-41	Cognitive/ emotional split. Feeling some responsibility for the suicidal client
M …I'm going to feel like I actually want to do more than the boundaries of my role allow me to do…? P I might feel- I never, I haven't done but yeah…	3	29, 12-15	Wanting to do more.
P I'm not taking responsibility whether they're going to live or die… M Right P …but I might have an impact on that… I don't know, I'd like to think that in a way, I suppose my orientation is to life… M Right P …errr… rather than facilitating it to death…	3	29, 43 - 30, 2	Suicide prevention.
P Working here with young people, yes, definitely, even if I might understand why they don't want to live and why their life is so shit… I can understand why they would want to do that and if they did it I would have that level of respect… but yeah, definitely I would have that sense that, you know, things can be different, they just can't… they haven't got any life experiences to actually feel any ups or changes… erm…	3	30, 7-12	Suicide prevention. Empathic response. Client autonomy.

M …feels like you want to take more responsibility for… for young suicidal clients… P Possibly, yeah… yeah… …yeah	3	30, 27-30	Perceived vulnerablity of young people. Feeling some responsibility for the suicidal client
P What level of responsibility… 'cause it feels different, 'cause I am accountable for my practice… M Yeah P …and I know I'd have to be able to if somebody did, you know… with records and things like that…	3	31, 21-27	Consequences of client suicide- professional and emotional
P Yeah, so it would be somebody who, you know, who hasn't got a good relationship with their GP, they've no family at all, they've multiple traumas, you know, very complex cases but very vulnerable… M And the less other support out there… P The less other support, that's… but that's when I DO feel that responsibility. Whether I then… have it… does it have an impact on me, determine what I'm going to do, erm… I don't know, maybe it would… I don't know, I… its… I think at the time it's hard to analyse it in this way…	3	32, 4-13	Feeling some responsibility for the suicidal client
P …you know what I mean? So I'm used to that pressure… but I'm really, really good at looking after myself. It might not always be immediate, you know, but I have lots of holidays, lots of breaks and lots of 'me' time and I need that to keep the balance in… M Sure P …if the balance wasn't in I don't think you could survive doing this… M No P …type of work of that sort of intensity really	3	32, 46-47	A kind of vicarious trauma.
M …how effective do you feel that is for your work with them? P …well, how do I measure how effective it is? You know, do they live or do they die? Erm… now effectiveness here we don't measure it in that way… M Yeah P …there's a real trusting… so I can't say how effective it is. I like to think that even with that sense of responsibility the effectiveness is… I don't know whether it would be exactly the same for… didn't have any responsibility…	3	33, 7-18	Feeling some responsibility for the suicidal client.Trusting the client, difficulty of
P …is it effective? I've not had any clients that have killed themselves but is that luck? Or is it my intervention, I don't…	3	33, 30-31	Client suicide as a professional failure
M …but it's difficult for you to say whether… feeling that greater degree of responsibility is actually going to be effective in your work with the client… P Yeah… yeah… M …any more or less than normally…	3	33, 40-46	Is taking responsibility effective?
P I'd like to say it doesn't effect but realistically I'm sure that there's some effect in there… Does that make sense, you know, that… M You'd like to feel that… P As a reflective practitioner I'd like to say 'yeah, it doesn't make any difference' but I'm aware realistically even having that sense is going to have an impact… M Mm P I mean I do think, there has been a couple of occasions where somebody has… one was around child protection, another was suicide where they didn't want me to tell anybody…	3	34, 2-32	Holding the situation- not breaching according to contract

M Yeah P …you know, and I can't remember all the details but it was, it was, as such within my professional capacity I could do that… but that did put a lot of weight on me… M Yeah… P But I knew by doing it I'd put the client at more risk… you know, and that feels a very different scenario than the other examples that I've given you M You mean by… by taking it all on yourself…? P Not taking it all on but by honouring that they don't want that disclosure going to…			
P I don't think so… I don't think so, I'm going to reflect on the last question I think… M Yeah P …a bit more… not at this moment but when I start having clients… about that responsibility and does it affect, but no… I think any of my sort of passions or thoughts and feelings about the subject area…	3	34, 32-39	Feeling some responsibility for the suicidal client. Is taking responsibility effective?
P If you ask me about compared to people that I know in mental health teams, and I did a course recently mainly with mental health, I think they've got their hands tied behind their back, you know with assessment and what they can do and can't do… M Mm P …I'm not judging that they're not doing what they should do, 'cause I know that the constraints that are on them… M Yeah P …so I think, you know, if I was to make a comment… I think it would be really… and counsellors working in GP practices… you know, I think they probably would answer this very differently…	3	35, 28-42	Working context, the effects of.
P …really chilling out… it's… it was hard just to get into gear and… er, even though I'd worked with some quite suicidal people here, from March, 'cause that's when I started, I was aware of how much of my previous work was coming in and how lack- how I didn't have the support and how that really, really had massive, completely different feel to it…	3	37, 4-9	Sharing or passing on the burden of responsibility
P …er and they have similar sorts of policies, the voluntary organisation is really, it's a harm to self and others is an exception to confidentiality… and I always make clear with my clients and I guess suicide is one of those that is always… it seems black and white but it can be a very grey area… M Right P …depending on really the er… the mindset shall I say, for want of a better expression at the moment, how the client is feeling at that moment in time… M Mm P …it's whether that's just something that they fling out as er… an offhand remark because they're feeling particularly pissed off maybe… M Yeah P …or annoyed or whatever in the situation… M Mm	4	2, 14-42	The grey area. Rational/ irrational suicide. Not avoiding the term, being specific.

P …or whether they truly are exploring the reality of wanting to commit suicide, erm… and that would be then followed up with erm… as I have done in the past, GPs, supervisors, you know, working my way through and erm… giving them my information regarding the client and certainly regarding one that really did wish to commit suicide was support workers that were involved in the case that I knew about… P …and how black and white are the exceptions and how are they not… M Mm P …especially at a Level 3 level anyway… M Sure, and as you said, it's one of those… suicide can be one of those issues which may appear black and white and then once you get into it… P Yeah M …it can be quite grey	4	3, 27-38	The grey area
P Erm… voluntary organisation… er… it's very much left down to the professional judgement of the counsellor… M Right P …and they would follow that through in… seeking support from supervisor, which I certainly did… with the… with the paid organisations there's very much more of… a structured format that you need to adhere to, to some extent…	4	3, 45 - 4, 4	Working within own professional boundaries and ethical code
P Yes, and I guess that… because there's something about I guess, something coming back on the organisation and their corporate identity I guess and they want to make sure that their guidelines are quite strictly followed into how they perceived it should be dealt with	4	4, 13-16	Client suicide as a professional failure. organisational safeguarding policy
P …and I guess my first port of call would be my supervisors… M Yeah P …and I know I would get some good support from them, erm… and if I was, you know, er… unsure as to how to progress then I would seek their support being more knowledgeable in that area or perhaps having more contact, certainly one of my supervisors worked a lot with a client group who had drug related issues…	4	4, 32-40	Sharing or passing on the burden of responsibility
M Yeah, it feels like there's a lot of experience there… P There is and I know that… you know, they wouldn't leave me to flounder… M Yeah P …I could certainly get some good support from them	4	5, 11-18	Sharing or passing on the burden of responsibility
P I guess in some ways I still follow my own judgement… M Right P …to some extent… at the end of the day… nobody knows the client better than I do… M Right P …and I guess it's going to be my judgement as to… having known them over X number of sessions, whether it is truly their intention to do what they say they're going to do or whether it's not… and therefore if that's the case then I would fully follow the guidelines… so to some extent I think I would still use my own personal judgement on that…	4	5, 26-39	Working within own professional boundaries and ethical code

P Hmm… erm… I guess… my initial session is always going to be to… to work with the client to see if we can have a working relationship, so to some extent, that is my assessment… M Mm P …both to give them the opportunity to see if they want to work with me… M Yeah P …and for almost me to see if they're suitable for what they want to… M Yeah P …come to counselling for. What further murkies the waters, is that… with the voluntary organisation I've got unlimited time with that client…	4	6, 5-20	Assessment, dialogic and continuous, client's 0-10 rating
P …and erm… it's trying to remember sometimes which hat I was wearing… erm… again, I knew I could always go to her although she wasn't my supervisor I could always go back and look at her notes that she'd done about the referral of this person to me… M Mm P …which were quite detailed, she took a… detailed notes of the family history… M Yeah P …whereas most often than not I've been used to getting little or nothing regarding that person, and in some ways I liked that, being a person-centred counsellor, I like a sort of blank canvas and not having my… the way in which I might work with this- tainted for want of a better word- by someone else's perception of that person, so then I've nothing to judge them on 'cause they just come to me fresh as it were…	4	10, 35 - 11, 2	Assessment, dialogic and continuous, client's 0-10 rating. Referral - no prior information
P Mm… and in fairness, you know, but key things like erm… certainly regarding the one from the bereavement agency, erm… the fact that she felt able to share that she had attempted suicide before, I think was quite brave on her part, she didn't have to keep that information prior to accessing the service that could have come just out in a session, so er… I guess that er…. I don't think it confounded me but it did make me feel a bit more er… careful in the way that I worked with her, erm… especially as things developed as well, I think that was, I tried wherever possible to maintain her empowerment but er… I don't think she wanted it…	4	11, 20-28	Responsibility transfer.
P Yeah, in fairness, all three agencies, erm… had set contracts, for the… it was already set out, which was useful, erm… boundaries were pretty much the same, some things were just operational for some organisations that they tweak things but you know, mostly it was about everything we share is going to be confidential except if you mention harm to yourself, others, and yourself, just going to mention something about breaking the law as well, might need to take that further with either my supervisor or somebody else but I would talk to you about that before I did that so I try to make that very clear and especially if someone brought it up within a session I would refer back to that as well so that before they continued exploring perhaps… M Sure P I said that, just for you to be aware, don't want you to stop sharing what you want to share but just be aware that within our original contract, this is what I said and… erm…	4	11, 43 - 12, 9	Formal contracting
P …and sometimes I've had to stretch those boundaries slightly just because… you've got some instinct that something isn't quite as it should be…	4	12, 37-39	Wanting to do more.

P Yeah and I would... say, you know, I usually tell my clients about ten minutes to go and five minutes and I'd done that with her and I said I realise we've come to the end of our time but I'm also aware of where you're at within this session... M Yeah P ...and I'm willing to give you an extra quarter of an hour but we're going to have to finish at the end of that quarter of an hour 'cause I've got to be elsewhere and I guess it's... giving that opportunity to further the session but putting some ending to it...	4	13, 2-12	Wanting to do more.
M Yes, I can understand that. So... does the contract itself bring up the issue of suicide or do you raise that, do you have a way of raising that yourself? P Not necessarily no, just harm to yourself, others... M Yeah P ...and just leave it at that, er... I don't like to emphasise anything in particular, erm... because it might not be something that's there that needs to be emphasised	4	13, 36-46	Being non-specific in contracting.
P Yeah, yeah. I think that's fair to say, erm... for me I don't know... I can't think of a reason I wouldn't want to mention it in general terms because, you know, I do know if I see a hundred clients in a year it might only be one client in a year, so why draw it to anybody else's attention if that... if it's not even on their mind... erm... erm... so no, I don't pick it up as something specific that I wanted to put as an exception to confidentiality...	4	14, 12-18	Being non-specific in contracting.
P ...and, you know, it's a general catch-all, 'harm to self' but, you know, clients who self harm, for example, you can go into quite some detail, so if I'm going to mention suicide, I'm going to mention self harm, I'm going to mention... other ways in which clients may try to injure themselves, erm... and we could say the same for drugs and alcohol to some extent...	4	14, 30-35	Being specific about self harm
P ...and lo and behold he'd only just got sat down and sorted out and that's what they hit him with and it really took him by surprise and erm... he didn't think that erm... the authority were very supportive of him and he said, you know, 'it was my blackest moment because I really felt like... driving my car into a brick wall'... M Yeah P ...so thought... 'oh, that's interesting...' so we went, you know, I said, you know... just refer you back to our original contract about harm to yourself, you know, and you're touching here on possible suicidal tendencies, I'm just wondering how real that is for you...?	4	16, 7-18	Referring back to the contract as issues arise.
P Erm... it didn't change much but his way of looking at that did change 'cause he realised that the only thing he was doing was harming himself and not harming anybody else M So almost having those thoughts going through it and being able to discuss it had actually changed his perspective in some way? P Yeah, 'cause they weren't bothered about how he felt about it... M Mm P ...it wasn't going to change their attitude towards it... M No... P ...and therefore, you know, the realisation therefore that it was down to him to change his attitude about himself and the way he looked at it and approached it...	4	17, 27-44	Value of offering space to speak about suicidal thoughts
P Hmmm... ...erm... until I became a counsellor I don't know if I really thought much about what suicide meant...	4	18, 1-2	Impact of own experience of suicide and of working with clients

P …my view is, you know, as individuals on this planet, you know, what we do or don't do with our own bodies is entirely up to us… M Yeah P …and although I as a counsellor and I as a human being might find that extremely difficult at times to understand why somebody might wish to do that… erm… at the end of the day it's not my life it's theirs and I haven't had their experience in life that they have…	4	18, 39-47	Client autonomy. Hard to empathise with suicidal feelings if you've never had them
P …and that might be more difficult to square the circle when you're thinking about somebody who's fairly young at the time as opposed to somebody who's a bit older…	4	19, 1-3	Perceived vulnerablity of young people
P …but, I think all we can do is educate people to some extent and try to find the solutions for them if they want those solutions but at the end of the day if we're going to take away the autonomy and empowerment of getting on with your own life then… they're not, maybe not going to be able to fulfil what they would like to do for themselves	4	19, 19-23	Value of offering space to speak about suicidal thoughts. Client autonomy.
P …that the number that have… made strong changes in their own private life as regards relationships and work related issues and things like that that have had quite a profound effect upon them and therefore if you take away some of that as they have found has happened previously throughout their lives… then… erm… we're just perpetuated what's already happening… and 'cause that's what I'm alluding to regarding suicide… er… by directing people what they should be doing about keeping alive… M Mm P …whereby if all they see is darkness around them and that's all they see, they've got to look forward to… M Mm P Then why should I take that away from them? That doesn't mean to say that we can't… M Yeah P …converse how this would… have this discussion… my facilitation of, of… enabling them to explore those deep and dark thoughts and perhaps getting a different perspective on it… doesn't mean to say that can't still go on… M No P …erm… but who am I to say that you should feel bright and breezy if you're feeling really down in the depths in life…	4	19, 43 - 20, 22	Value of offering space to speak about suicidal thoughts. Client autonomy.
P …I don't know, it's… I think we're all, at the end of the day it's about accountability isn't it?	4	21, 25-26	Being a responsible professional. Consequences of client suicide-professional and emotional
P …can I capture that…? For me it's about being able to facilitate where they're at with their… suicidal thoughts, whether they be real or otherwise… M Yeah P …and I guess there's always an element of… erm… truth about exploring this if… if someone's in really a… a dark place within themselves and they don't feel that there's any way out of that… M Yeah P …is… is… erm… is to allow them to look at what that's all about, er… and how they can explore it… erm… I certainly don't try to make it rosier than it is…	4	22, 1-27	Value of offering space to speak about suicidal thoughts. Client autonomy.

M Yeah

P ...yeah, 'cause that comes from my frame of reference and not from theirs and there's always the temptation that you might want to do so...

M Yeah

P ...not all but at the end of the day, you know, as you know, these things that we say to brighten, cheer people up but in a counselling role, you know, it's having to keep that professional... that professionalism of working with the client...

P Yeah, 'cause quite often... I'm sure you can identify being a counsellor yourself... that you know, that therapeutic hour that we have together with a client might be the only space in which they're able to be open and honest with themselves to be able to explore those thoughts...

M Yeah

P ...because other people... don't want to know, it's too frightening for them, or maybe they're not open and honest enough with other people either...

M Mm

P Because they may be frightening them away...

M Yeah... so that's what we can offer them in that case...

P Yeah...

4 | 22, 41 - 23, 8 | Value of offering space to speak about suicidal thoughts

M So was it covered specifically in training or did it just come out?

P Er... I think it came out in the training as exploration of...

M Right

P ...you know, here we are, we're on the diploma now, certainly on the diploma course now and 'what would you do?' You've looked at this on Level Two, you've done this on Level Three but now you're at a stage now where you're having to put it in serious practice and being out there with live clients as it were... and therefore if you're going to do these then you need to explore these sort of issues and what would you do with it, where would you go with it, how would you handle it...

4 | 23, 21-33 | Vague memories of training

P ...again, you know, black and white would say this is what you need to do but in fact when you've got... when you're in the mix with the client, is it going to seem more grey than it should be?

M Yeah... that's er...

P And, you know, there was some really good discussion and support, I wouldn't say direction from the tutors at that time and what I mean by direction is they weren't directing us to say what we should be doing but they were directing us to explore it in depth and to share experiences if we had any...

4 | 23, 27-47 | Training facilitated exploration of issues without being directive.

P Yes, it's the swan moment isn't it? You know, you're calm and serene on the outside and your stomach's churning up inside and... you know, you're pedalling furiously in your mind trying to think 'ok, so on a scale of nought to ten, where might this lie...

M Yeah

P ...with what the client... ok so let's work through the process with them as to where they think they're at. Is this just something that's come up, like my client, that one off moment, well, I guess if he hadn't got a family, if he hadn't got a good strong bond with his wife, he may have just actually driven into that wall that day...

4 | 24, 28-39 | The Swan'.

P 'cause being aware that the last thing I want to do is for me- 'Oh my God!' you know… M Yeah P …they're going to commit suicide! (laughs) I have seen students give that reaction, certainly on level three, well ok, how helpful is that going to be for the person you're listening to as a helper and you know, really, it's not… and you know, I see myself as reasonably experienced now after nine years…	4	25, 29-38	The Swan'.
P …and that's very true, very truly the case and therefore if we look at particularly to do with suicide, trying to remain calm and trying to work through with the client just where they're going with this… M Yeah P …is it just a heat of the moment thing, is it something they've planned, is it something they're contemplating, is it something they've heard of other people doing and it's their… a way out of the situation…	4	25, 48 - 26, 6	The Swan'. Anxiety-driven exploration of extent.Rational/ irrational suicide
P Erm… for my male client yes, I was quite… I felt that it was quite strong of him, he didn't have to say that he'd contemplated that 'cause I can't see what… how that would have changed any outcome unless he was thinking of following it through at a later date… M Mmm P …but he was quite open and as I said, you know, it was just a flashing thought while I was sat there thinking about before I drove home, er with the other one I guess, having someone who had a history of attempted suicide then erm… and the way that her life wasn't turning out as she expected…	4	28, 2-13	Glad they've shared suicidal feelings.
M Yeah… so… what do you feel about yourself as a counsellor in those moments? P …erm… trying to remain calm I think is an important one… M The swan! P Absolutely, it would be so easy to be get drawn into trying to rescue and save the client and I was desperately trying not to do that and I was well aware that that would be so easy to get sucked into that… she I think I alluded to 'you're looking for a knight in shining armour and he's not coming' and she acknowledged that that's how she saw it… M Yeah P …and I think I even said 'I hope you don't see me as that knight in shining armour 'cause you know I can't be'… M Yeah P …which, erm… which… she sort of looked at me strangely initially… M Yeah P …and I said, you know, this is not the kind of relationship that we've got, this is my relationship with me as a counsellor and you as a client and I'm not here to rescue you, you know from the sessions we've had…	4	28, 39 - 29, 15	The Swan'. Client autonomy.
P Yeah, yes… and you know that feeling, getting drawn and drawn and drawn from the client as they build layer upon layer of how desperate their life is… M Mm P …and trying to remain that… professional distance between you and	4	29, 30-37	Being a responsible professional. Wanting to do more.

them…

P …I try not consciously to… but I think… try and take a deep breath without them being aware that I'm taking a deep breath… just try and keep a clear head, try to focus on what they're saying, pick up the nuances, certainly the body language, I mean… there might have been some… some… subtle hints before then anyway, trying to see the person as a whole person anyway rather than just necessarily what words they share, what their body language is telling me, how they're sat… erm… is it different to how it has been in previous sessions, are they more agitated than usual and just really trying to be aware and connect with where the client is and try to explore that with them if they're willing to do so…	4	30, 5-15	The Swan'.

P Erm… I don't think I disconnect as such but I think I'm aware that… erm… I need to keep my focus and probably be… erm… er… what's the term I'm looking for…? Erm… just remain attentive… M Yeah P …to where they're at… M Mmm P …and that whatever's going on for me needs to be put on the back burner and taken as soon as possible to supervision, erm… M Yeah P …but at this moment in time it's the client that needs my attention, not me M I see. So it's almost as if the magnitude of the issue is perhaps… you're aware that it might distract you from being there in the moment… P That's exactly it… M …and therefore you're having to put effort into… P Yes M …into sort of putting… keeping that to one side P Yes, that's exactly it	4	30, 25 - 31, 4	The Swan'.

P …and realising you know, I needed just… I needed to hold this and put it to the back of my mind and remain focused… M Yeah P …and, and… really to some extent… erm… be attentive that I don't miss something that could be quite crucial at that moment, especially with the lady… I think more so than the gentleman because of the previous history… M Sure P …because, you know, this was… a truism for her that it was likely that she would or is going to attempt it again in the near future or not too distant future and therefore, you know, trying to make sure that I don't miss like a key… M Yeah P …in my supporting her maybe changing her, changing her decision…	4	31, 25-44	The Swan'.
P So, I guess I… I'm laying my cards on the table M Yeah, sure P …as she had with hers, not that I was trying to distract her from what she was doing…	4	32, 26-37	Congruent concern'.

M No P …but just saying that I was taking it seriously and that if that was her decision then I also needed to make a decision as to what I was going to do with that information			
P …and then I realised that our way of dealing with that was very straightforward that within our session the client had the opportunity to share with me whatever they wanted, of course, got to realise, you know, that stuff belongs to them it doesn't belong to me… M Mmm P …so although I don't mean it flippantly I'd say something to the extent that my summing up of bringing this session to a close would be giving back what they shared with me so hopefully in my summary… showed that I'd been actively listening to what they'd shared with me… M Yeah P Empathic in what they'd shared as regards thoughts, feelings and meanings regarding the issue but that was my way of hopefully giving it back to them rather than me keeping it from me	4	33, 36 - 34, 3	Sharing or passing on the burden of responsibility
P Because otherwise how could I be empathic with the client if I'm deeply in touch with them in that way. I'm not going to be able to work at any depth with them if I'm not going to be understanding it from their point of view, you know, you truly feel what they're feeling about that issue. If I'm not going to be able to do that then I'm not going to be able to work with them as well as I could do	4	34, 8-13	Empathic response.
P …so therefore I guess it's always… it always does trouble me that it's something still then rattling round in my head, that's something I need to write down and take to my supervisor and wonder why is it still rattling round in my head…	4	34, 21-24	Feeling some responsibility for the suicidal client
P …and at the end of the day we're going to have to go our separate ways… M Mm P …so as long as I feel that I've… done all I can do as a professional counsellor in facilitating what they've brought within that session, whether it be something to do with… initially to do with suicide… M Mm P …and that's all I can do… even if that means that after the session I then make some phone calls or contact certain people…	4	34, 36-48	Value of offering space to speak about suicidal thoughts Sharing or passing on the burden of responsibility
M So how much responsibility do you take for a suicidal client? Or… it feels as though you may take it in the moment in the session… P Yeah M …and then you seek to sort of then… dissipate that afterwards in whatever appropriate ways you feel P I think that's a great way of putting it, yes, I think that's how I would… how I have done it, you know that one particular client, it was really an issue, a case of holding in that moment, going with that, facilitating it, exploring it and I felt, you know, as much pain as the client was feeling as well…	4	35, 15-27	Sharing or passing on the burden of responsibility. Feeling some responsibility for the suicidal client
M Right, ok… So it feels as though you might be taking on responsibility when they raise that issue as you said, there's the legs of the swan are going, you're working harder, you're then either you're… handing things back to the client or you're passing things on to other people… P Yeah M …you're dealing with things and then once you've done that, that burden is then gone from you and that responsibility isn't there? P …it would be nice to think that… that happens 100% like that…	4	35, 42 - 36, 2	Sharing or passing on the burden of responsibility.

P What if he didn't have those people and be worried about if he had taken his life by driving into a wall… and may then just have found out that he'd committed suicide and wonder what the hell was all about M So in an ideal world, you've handed things on to other people… P Yeah M …so that you no longer have it but then it sounds like there could always be that 'what if?'… P Yeah M …and that might still play on your mind… P Yeah… yes, and I wouldn't say that it's there all the time but I guess, you know in peer forums, you know… M Yeah P …counselling peer forums when we're exploring issues that we've had with clients and not of course, you know… remaining confidentiality regarding clients is sometimes about exploring 'what if?' moments and I guess that was one of those that 'what if?'…	4	36, 24-47	'What if?' anxiety
M So it feels like, yeah, you can manage the thing as best as you can but you can't allow actually for all of the 'what if?'s… P No, no…	4	37, 26-29	'What if?' anxiety
P …and there… in any case, who am I to say that… erm… I should dissuade her or anybody else should dissuade her from that action if that's… how she feels about where her life is…? And that's not an easy thing to discuss or consider… I've never been to that place myself but I've certainly felt it on behalf of somebody else and that's… afterwards it's a very uncomfortable place to feel as a counsellor that's where someone's been…	4	37, 33-39	Client autonomy. Hard to empathise with suicidal feelings if you've never had them
P Yes, just to end with my lady, erm… that particular session when I told you that she had the paracetamol and the Stanley knife and knowing she would go home, she would get a bus to take her home and she lived about a ten minute bus ride away… erm… and… I made a judgement that I had an extra long session with her, it was about an extra fifteen minutes and I was so not unsure that she was actually going to get the bus to go home and she'd been mentioning these things and she sort of showed me them and erm… I said how are you going to get home and she said 'I'm going to hang around for a bus' and I made a judgement call and I'm still not sure if it's the right one that I offered her and did take her home…	4	38, 1-11	Wanting to do more. Is taking responsibility effective?
M So it felt like that… you kind of… again I suppose you'd stretched those boundaries on, on trusting your judgement… P …and it was a huge sense of relief that she, you know, placed those on the seat as she left the car and walked home M Mm P But I think, as I said, there was a sense of… just delaying the inevitable to some extent M So even though you kind of… I guess it could be argued stretched those boundaries quite a bit… P Yeah	4	38, 41 - 39, 21	Wanting to do more. Is taking responsibility effective?

M …it had perhaps… prevented it at the time or it had, you know, had that outcome but it didn't necessarily prevent it happening two to three weeks later P No M Yeah. So even though you can still go that little extra bit… P Yeah M …it may not even… P It may not be far enough. Yeah. That extra mile might not be far enough because erm… I don't know why she did that and decided to give them to me but it was a huge sense of relief for me that she did			
P …and… try not to beat yourself up about 'what if's, 'cause we can… 'what if's if we look throughout our lives can't we? And I guess you know, the fact that she did what she did I guess that extra mile was, you know, never going to be long enough… M Right, yeah P …that… that was my… she'd find some other ways and means of doing what she wanted to do…	4	40, 3-11	Is taking responsibility effective? 'What if?' anxiety
M How do you think other counsellors may have answered these questions? P Ah! I would hope with similar honesty about their experience	4	40, 17-20	I've given honest responses, would others?
P …and I would expect them to… to er… to respond with similar candity about erm…	4	40, 29-30	I've given honest responses, would others?
P …erm… our views agree on a great many thing but sometimes it's about being in the moment and deciding what you're going to do in the moment… M Right P …and some people might have taken it to the 'N'th degree or marched them along to the GP practice, you know, I don't know… erm…	4	40, 38-45	Working within own professional boundaries and ethical code
P Yes, I'm interested in that idea of suicide and how does that affect me and I work privately and I deal… I deal with it differently in my private work than I do in my work here…	5	2, 1-3	Working context, the effects of.
P Erm. yeah, erm… I do… I do… we don't call them policies but we do call them guidelines, there's things I've put together and, and then with the approval of my line manager once I've written them and he's maybe tinkered around with them then we make general procedure within the service, when I talk about the service there is only me but I have trainee students coming in and working as well… M Yeah P …so it's important they're clear about what to do… so yes we do have some guidelines that we have set out erm… and that is… I mean, from my own point of view I would talk to my supervisor if I was really sure that there was intent and ideology there, you know… Ideation I should say, erm, for the client to take their own lives… there's also… we have… in the college where I work what I've brought in the college is a sort of	5	2, 13-33	Conflicting policy demands

statement of how we deal with students in distress and the idea of serious self harm and suicide is covered in that… erm… M Right, so that's almost a different layer is it? P A different level and it's for all the staff, that, how to deal with it			
P …and they also help them to come into the college, so if they know of them outside in the community they'll help them to… you know, make that step into the college to come for education… so the college employees are… it's indicated that if they know of any suicidal or self harming clients, serious self harm then they're referred to the two mental health tutors and then they'll refer on for counselling or they might refer out to CAMHS or you know, whatever agency that they need to do	5	3, 9-15	organisational safeguarding policy
P In the past I've just had a very loose assessment process but I'm experienced and I know what I'm looking for… M Yeah P …and I'm experienced with… er… you know, depression and the symptoms of depression and anxiety and I would refer to the GP if I thought that those issues were raising themselves either in assessment or through the therapy…	5	3, 38-46	Assessment, dialogic and continuous, client's 0-10 rating
P …but, just recently I've been looking at the GAD7, the PHQ9… M Right P …all these things are measuring aren't they… M Mm P …like assessment tools for measuring anxiety and depression… M Yeah P So I'm just about, I've not used them yet but I've got them there on the desk… so I'm going to start to incorporate that into the way I assess…	5	3, 50 - 4, 13	Assessment, dialogic and continuous, client's 0-10 rating
M So I guess what you're saying then is… I suppose in risk assessment terms it would be called a dialogic risk assessment… P Yes M …so you're using your knowledge and experience in your… you've got an idea what kind of things you're looking for… P Yeah M …so it's in the dialogue you have with the client… P Yeah	5	4, 15-27	Assessment, dialogic and continuous, client's 0-10 rating
M …but you're looking at adopting some of these more formal ways… P Yeah. The reason I'm doing that actually is 'cause I've just started working with [….] and incorporating the idea of the cognitive behavioural or the computerised cognitive behavioural ideas… M Oh yeah P …so I'm sort of testing that out this term to see how that goes as a way of alleviating… not alleviating the waiting list but of putting something in place for those students who maybe aren't as severe… a risk… but there is something for them to potentially be getting on with while they're waiting to see me, this is CBT…	5	4, 29-41	Assessment, dialogic and continuous, client's 0-10 rating
P Well, occasionally the tutor might need to offload what they're experiencing from the student… M Yeah P I don't… I prefer not to know but I understand… M You prefer to kind of see them as a client… P Let me see them and perceive them the way they come to me, but I understand that the member of staff may be feeling stressed or, you know, concerned about this student…	5	4, 47 - 5, 8	Referral - no prior information

P ...which is slightly different really because I would explore the ideation and dependent on how I feel and I've not been very specific in my guidelines about how I work, I would talk with my supervisor and I would take it from there, the trainees who come into the service I'm a bit more specific 'cause I ask them to come and talk to me about it and also to discuss it with their supervisor so that I have an overall... I have overall control about what's going on in the service I manage... M ...either from the college or that you've set up yourself, so then it feels like a lot of that is down to your judgement...? P It is really and I suppose it's... maybe it's based on that person-centeredness that I have about me because I want to experience the person, the client in their... where they are in their... M Yeah P ...in their place... M Sure P ...and work from that point...	5	5, 45 - 6, 2 6, 9-22	Working within own professional boundaries and ethical code Working within own professional boundaries and ethical code
P Ok, just going back to what we were talking about before, just to put another level in, 'cause we are... we have to have a safeguarding procedure and we have a safeguarding officer in the college... M Ok P ...and there is a protection of children policy, vulnerable adults and young people policy in place as well, so I just wanted to add that in...	5	6, 34-41	organisational safeguarding policy. Conflicting policy demands
P It does and it doesn't... 'cause there's one sentence in the policy that says the counsellors in the college do it differently, sort of thing M So you've got your own... there's sort of an exclusion... P ...and I fought really hard for that... M Right, that's interesting... yeah P ...I fought really hard, because originally the policy wasn't writeen like that and when it was being reviewed four years ago I fought and fought and eventually it went through to the governing board that we could put that in that the counselling service was the only place where we could talk about suicide and child protection issues and it not necessarily go to the safeguarding officer...	5	6, 45 - 7, 9	Working within own professional boundaries and ethical code
P Well, erm... I'm not so sure because I follow the BACP ethics and erm... you know, and that's in my job description that I should do that so there's a strong argument for me to do that to be able to override the policies but I wouldn't like to have to do it... M No P ...and interestingly enough, when all of that was coming about... I contacted my professional indemnity insurance people... M Right P ...and asked them how would they support me if... erm... I didn't disclose before the policy was changed, I didn't disclose... M Yeah P ...how would they support me if later on that came under some sort of... and they said they would, they would support me, which I found very comforting	5	7, 14-33	Working within own professional boundaries and ethical code. Justifying working to BACP guidelines instead of organisational policy
P In defence of the employer I would say that once I've been able to sit down and explain the dilemma and the ethical issues that are around that type of stuff... M Mm P ...they have actually been able to say 'oh yes, [....] has a point and to	5	8, 1-8	Working within own professional boundaries and ethical code. Justifying working to BACP guidelines instead of organisational policy

allow me to do what is necessary…

P …so they do actually listen but it's because… I mean I always… it's quite hard working in an organisation like this because the main focus of this organisation is not… it's about education… M Sure P …it's not about therapy… and I'm here… hopefully they see it like this, anyway, the management, that I'm here to help the process of education… M Yeah P …but erm… I'm the only person who understands my profession and I'm a very different professional… M Mm P …in this organisation… there is, apart from the fact we have the training team over in another building from where I… although I do cover the whole college, we do teach counselling here…	5	8, 12-31	Working context, the effects of.
P …but apart from that there is nobody here who actually understands this profession, 'cause they're all teachers and administers and managers and I'm a little one on my own here… M I guess that could make you quite isolated, particularly if they weren't prepared to back you, that could be quite a… P It is, yes. Erm… and I do things to work with that, I have a lot of friends who are counsellors, I'm on a what they call a 'jis' mail service, a joint information service, so I can send an email, you know, if I've got a dilemma or I'm not sure what to do with something I can send that email and it goes out to a huge group, a network of all college and university counsellors and they can come back to me and give me ideas	5	8, 35-47	Working context, the effects of.
P …I make that quite clear in the contracting… so then I explain there are three exceptions to the confidentiality issue, one is around erm… if they're feeling suicidal then I would want to talk to them about that and I MAY, and I use this word a lot in this, I MAY want to discuss that with their GP or another medical professional just to get some extra support on their side and I'd let them know I was going to do that…	5	10, 28-33	specific written contract
P Let me read it to you… it says that the counsellors in the counselling and wellbeing service will not talk to you or what you tell them to anyone else unless they have your written permission to do so or in exceptional circumstances as detailed below. In cases of imminent danger to yourself or to others… including suicide and serious self harm…	5	10, 48 - 11, 2	specific written contract
Yeah, ok… so it feels like it's still, even though that's quite specific and comprehensive, it's something that you've drawn up largely… this isn't something that's generally imposed upon you and you've chosen to do… P Yes, yes M …and it leaves a lot down to your judgement… P Indeed M …it feels like P It does M Yeah P Which I like… M Yeah? P …'cause it gives me that ability to work with the relationship I have with the client… M Mm P …and I think it offers that element of trust… M Yeah	5	11, 48 - 12, 28	Working within own professional boundaries and ethical code

P …that they know… the only time that I would never explain what I was doing is if I had to report something to the police…			
P …and he might make recommendations… and I was very lucky to have this boss… and it does worry me how it will be when we get a new person which we've not appointed yet… M Mm P …because he would… if I said… ok I'll listen to what you've said, I need to go and talk to my supervisor, if I came back and said well actually, my supervisor says different to you, then he would work with that, so I was given a lot of my own… space really to work in…	5	14, 3-12	Importance of good relationships with superiors.
P But I think it's… I've always borne in mind, you know, the autonomy, all those things of the client as well…	5	15, 3-4	Client autonomy.
P …I'm not saying that I wouldn't want to contact the GP or someone else if a private client was… you know, suicidal… but… I believe that a human being has a right to take their own life if that's really what they want… M Yeah P …and I know that puts me- I thank God that that never has happened… M Yeah P …erm… but I believe that that gives the client… you know, the right to be… self governing and have that autonomy, which is so important to me…	5	15, 36-49	Client autonomy.
P …and… and thinking back to my private practice and I can't… I can't ever really think that I've had someone that is absolutely to the point of going to do it but I have had clients in here who I have allowed them to have that space… M Yeah P …and they have not committed suicide… M Mm P So… and I've given them a lot of support… erm… but they haven't gone and done it… So I do believe that, you know, a human being has the right to take their own life if that's what they want to do…	5	16, 3-16	Client suicide as a professional failure
P …for all sorts of different reasons, but ultimately I don't know what it would be like if I knew there was a private client saying that well, I'm going to go home today… M Mmm P …and I'm going to do it. I'm not so sure that I could hold onto that, to be honest…	5	16, 27-34	Working context, the effects of. Feeling some responsibility for the suicidal client
M Yeah. Ok, well we'll get onto that a little bit… I mean, you mentioned a little bit there about, I guess, I mean, what do you see of the role of counselling with clients who may be feeling suicidal, what do you feel counselling can give them? P To allow them that space to make that decision if that's what they need to do, if that's what they want to do?	5	17, 6-18	Value of offering space to speak about suicidal thoughts. Suicide prevention.

M Even if that means making the decision to die…? P Yes, I mean, it's difficult 'cause I work in the college and this organisation would quite understandably, quite rightly want me to stop that from happening…			
P …and it's an awful thing to say but I know exactly the reason why is because they don't want their name all over the front page… M Mmm P …of the local and national newspapers, you know 'student at college commits suicide'… M Yeah P …even though they'd been seeing the counsellor, you know, they don't want that… M No P …and that's really hard line but it's true	5	17, 22-37	Client suicide as a professional failure
P Well, there's always that conflict because I, you know, I need to hang on to the ethical code… M Mm P …and that sense of autonomy. At the same time… I work in an organisation that wants different things… M Yeah P …and is led in a different way so… you know should that dilemma ever really occur, and I have to say… you know, I have had clients who are suicidal but… they've always… they've always left each session and I've always felt confident that they will come back, that's quite a strong thing to say but I have…	5	17, 45 - 18, 10	Conflicting policy demands. Holding the situation- not breaching according to contract. Client autonomy.
P Erm, and erm… so I… I check out, you know, what will you do if it is Sunday afternoon and you just feel… you can't go on another minute, what will you do, how will you deal with it? M Yeah P …and I've explored that and they always come up with stuff… now it may be that they're just… you know, making me feel ok about it…	5	18, 34-41	'Putting up the safety nets'.
P …but she brought it in and we talked about why she'd done that and not ended her life and why she'd brought the letter in, so you know, everyone's different and they all… …I think what I'm saying there is that… it's work to work with… D'you know what I mean? M No, I'm not… how'd you mean? P If they, if they're saying they're suicidal and they're going to do stuff then that's… that's stuff you can work with in the room with them… M Mmm. So rather than immediately… you're saying… P …a kneejerk reaction… M A kneejerk reaction… P I'll allow them to go down that route for as long as I dare… and it's a risk, it's a dilemma…	5	19, 1-18	Value of offering space to speak about suicidal thoughts. Glad they've shared suicidal feelings.

P …I know she would so I know she's there… I have great support around me actually, I do, it makes me realise that more again… erm… but she's always given me that space and that autonomy to allow me to deal with the client…	5	20, 39-42	Supervision as a safe space
P I'm not saying that it's a recipe for success but my experience has been that it's always worked… to say, not to say 'yes, go and do it' but to say 'ok, let's look at that, what's that going to mean for you, you know, how's it going to be?'… M That actually, instead of sort of saying 'ooh, now you've said that'… P I'm out the door and I'm going to have to do something… M …is to actually kind of… 'ok, yeah, let's work with that' P That's what I'm saying, it's work to work with, content to work with, that's what I meant	5	21, 25-37	Value of offering space to speak about suicidal thoughts. Client suicide as a professional failure
P …that's probably a bit of a generalisation but… I find that if you get to that level… then… there becomes a discussion about what happens when you die and what's your belief system and… M So you're getting into some quite deep stuff… P Very much so yeah… and actually that, then, I mean, I'm thinking back to those experiences and those clients where that's happened, the depth of relationship is HUGE, you know and it's quite hard when they say goodbye then for me and them 'cause you have shared at that level M Talking about that sort of fundamentally deep stuff about the fundamental meaning and nature of life I suppose… P Yeah M …that actually forges a deeper… P Mm M …bond in a way… P …and it allows them to explore… that's right	5	22, 6-28	Value of offering space to speak about suicidal thoughts
P …and I value that highly but I'm glad that I work integratively and I have other ways to… you know other things to throw in the pot… and I think it's my person-centred training that's given me that… ability and that understanding of autonomy… I'm going back to that word again… M Yeah P …so the client has the right to do as they wish…	5	23, 21-28	Client autonomy. Value of training in recognising we can't know how others feel
P Yeah, erm… yes, and erm I mean there was always differences of opinion but the tutors were good because they never said 'you must do this, you must do that' they didn't produce cloned counsellors… M Yeah P …of themselves, they allowed us the space to explore how we felt as individuals about it… and to discuss it in an open forum with other students, erm… it was like a sort of debating type of thing, you know, where you could discuss it and maybe go away and change some of your thoughts and your thinking processes about it but it helped me to formulate some of my ideas… M Yeah P I think person-centred for me, I think it did that for me…	5	23, 32-47	Value of training in recognising we can't know how others feel. Training facilitated exploration of issues without being directive.

M Ok, erm… I'm going to move on now on to actually that moment when, let's say a client discloses that they are suicidal… what kind of things… are going through your mind, what do you think, what do you feel? P …I suppose a sense of… erm… oh- this is a gut reaction, an initial sort of very emotional response from me is 'Oh God, I've failed' M You've failed? P I've failed, because they've not got better, not… erm… it sounds awful this, they're not cured but I have to take responsibility for that thought then, so it's like- 'well hang on a minute, is that what I'm here for?' M Yeah P You know, so I have to do that bit of logic-ing that bit out…	5	24, 32-47	Initial panic/ anxiety. Client suicide as a professional failure
P …and then I suppose a sense of… I might have a sense of panic… a gentle sense of panic… and er… one of our tu- I did my supervision a while ago and my supervision qualification and one of the tutors used to say 'when you feel the panic rise- sit on your panic'… what she was sort of saying was push it back down and just work- try and take control of that and listen back to your client… M Mm P …so I'm aware that I can sometimes go into 'Uh! Christ! What's happening now, what am I going to have to do?' M Right P So I suppose it's like going to red alert really… M Yeah P …I'm becoming very aware now, hmm. I need to be really, really careful what's going on here, I really need to assess exactly where we're up to… and I may at that point become more directive rather than non-directive as in I may start to just ask a few questions, to explore… the ideation of that client and where are we with this, is this like… is this just a passing comment 'I wish I were dead' or is this a real… 'I am going to do something about this' so it's about pulling all of that out…	5	25, 1-25	Initial panic/ anxiety. The Swan'. Anxiety-driven exploration of extent. I've got to work harder.
P Yeah, I would never veer away from it… M No, so… P …never veer away from it… M Right, it's raised so now I need to… I guess the sense I'm getting from you is 'I need to explore the extent of this'… P Yeah M …'how serious is this, what am I actually dealing with?' P Yeah, yeah… so I might… so when I say I ask questions, I'm not talking about why or whatever but I may become a bit more enquiring about it… M Mm P …what's where, how have you come to that decision… what's, what's the thoughts that you're having about it… M Mm P …and looking… have they got a plan, where are they in the process of this suicidal… idea…	5	25, 30 - 26, 4	Not avoiding the term, being specific. Anxiety-driven exploration of extent.
P How do you think, you know, what do you, where and what shall we do? Co-operative work, now what shall we do about this? Erm… what do you think I should do about this? And then I would tell them how I was feeling… M Yeah	5	26, 30-40	Congruent concern'.

P …where does this leave me? If you do do this, where does this leave me… as an individual, as a human being, how am I going to feel? As an employee of this college? What impact is it going to have on me? Erm… so I'm helping them to see the consequences…			
P Yeah, really unpack it, so I do focus a lot on it, I would never run away from that…	5	27, 3-4	Not avoiding the term, being specific.
P …it's like a rai-, it's a sudden raising of like… 'Whoa! I have to be REALLY, REALLY careful now… I really have to work hard at this'… So it's like erm… I don't know how to explain it but I said it's like I'm on red alert now…	5	27, 18-21	The Swan'. I've got to work harder.
P Yeah, that's true but then and that's true but if I still had… those sense of… it's about appropriate congruence at the appropriate moment here isn't it, because… I would still… if I felt that there was real… intent… then I would go down that route of like congruence at that point for me- this is where I am with you saying this now…	5	27, 45-49	Congruent concern'.
M So you would use your own experience… P Yeah, absolutely… M …in a congruent way… P You know, I may be feeling let down at the moment or I've let you down or I… you know I'm sad that you feel like that, I'm sad that you've come to that point or… and then that dialogue about… I wonder what you think might… how it might impact on me if you do go away and do this? M Mm P Erm… I don't know whether that's… I don't know whether that's a bit manipulative really, but…	5	28, 5-19	Congruent concern'. Challenging with the ripple effect
P That's where I'm just getting to… it's like… that's an interesting one because… I'm asking… I mean I will explore how it's going to affect other people in their lives, so I'm sort of… I'm drawing to their attention there are consequences to their actions even if they're not alive any more… M Mm P …and those consequences will… ripple out to all parts of their lives, including college… M Mm P …and me… and do they- have they considered that? And how do they feel about that? So it's not in a nasty authoritorian [sic] 'you shouldn't do this because it will have an impact on my life, do you know that I could get the sack, blah, blah, blah'… M Yeah P …it's not that, it's more a… you know, how would you feel, knowing that this is how I felt if you did that…?	5	28, 28-49	Challenging with the ripple effect
P Because it is a relationship. I have a relationship with the client and I… I… my intent is always to have an equal relationship… M So P …so ultimately, you know… I have a right to feel the way I do, if they have a right to feel the way they do, then I also have a right to feel the way I do about their actions… M Yeah, yeah… P …and I need to be able to share that with them because… ultimately, later down the line, hopefully they've got through that suicidality, that will buoy up the relationship later on, that level of trust is there, it's grown…	5	29, 13-40	Congruent concern'. Value of offering space to speak about suicidal thoughts

M Yeah P …and the depth is there and grown in the relationship… M Yeah P …and the relationship's key isn't it? M Yeah P Now ultimately the relationship is key and I always have to hold onto that 'cause hopefully this is a… it's one point in the relationship… and the relationship will continue after that point…			
P It's a dual struggle then isn't it, I mean it is, isn't it, it's a journey that you're both on… M Sure P …and it's a… it's a way of them understanding that you're both in this together…	5	30, 1-7	Value of offering space to speak about suicidal thoughts
M So to perhaps go back to your feelings are sort of… your first feeling is you've sort of said is you know, 'I've failed, I must've, I mustn't have… I must have failed in some way if they're feeling that way' P That dips into my own stuff that… M Yeah P …that's what that is… M Yeah P …I hate to fail… M Right, so it feels like it's a failure if they're feeling this bad… P Yeah… yeah	5	30, 9-25	Client suicide as a professional failure. Being a responsible professional.
P Oh my God, yeah, that's right, I've not resolved their issues and then I have to do the logic of… hang on a minute now, that's not why you're here anyway… and… erm… you know maybe this is part of the healing process, they need to go that low to come back up…	5	30, 29-32	Client suicide as a professional failure. Value of offering space to speak about suicidal thoughts
P …and I had the greatest of admiration for him… M Mm P …you know, it was an honour… it really wa- I know that we use that term a lot but I really mean that, it was an absolute honour to work with him and know the strength of his faith…	5	31, 27-33	Value of offering space to speak about suicidal thoughts. Glad they've shared suicidal feelings.
P …it was amazing actually… but my gut reaction at the beginning or my first reaction was, that sense of deep sadness, you know… am I answering the question?	5	31, 37-39	Empathic response.
P Yeah… yeah… yeah… it was, it was excruciatingly sad for him… M Yeah P …he was very sad… M Mm P …and I felt that sadness… M Yeah P …and erm… I know from time to time I was… you know I was… you know I felt my emotions raised, you know… M Mm P …I might become… not saying I wept openly (laughs)… but you know I would… M Mm	5	32, 1-31	Empathic response.

P …I'd feel that sense of like tears and, and yeah… M Mm P …and occasionally I have cried with this client… M Yeah P …at his… his absolute desolation…			
P Well, I would… I- before the end of every session, whether a client's suicidal I always say 'where are you at now?' what have you got from this session, so I would probably home in a little bit more about, you know, how are you feeling right now- do I need to do something, I'm checking out with the client, do I need to do something? How do you want me to react, where… what are we doing about making another appointment and with a suicidal client I'd say 'what's happening now, where are you going now, what have you got on till the next appointment- do you want to see me later in the week, erm… how are you going to cope with the weekend, the lonely evenings, you know when college isn't open…'	5	33, 13-23	Assessment, dialogic and continuous, client's 0-10 rating. Anxiety-driven exploration of extent.
P …erm… but I will make sure that they know that there is a lot of support around them… if I'm really concerned that there isn't a lot of support around them then I guess that alarm bells start ringing then… M Right… and in which case… what would you do then? P Well, I think at that point I would have to do something, it would have to go out of this door, I would have to say, 'look, I'm really concerned about you'… M Mm P I really think that, I've listened to your plan, I know where you are with it, I'm really assured that's where you are with it and I refer back to the contract, you know, the boundaries, I have to do something with this…	5	34, 25-39	Suicide prevention.
P …and I wouldn't let them go, I would want them to stay until we've got that resolved, I'm not saying I would have them sat in that chair but I might ask them to stay in student services or I might ask somebody to just be with them… M Mm P …while we're resolved… M Yeah P …and got to the bottom of that. Erm for me, you know, if I had other clients I might have to put… you know, I might have to do something about those and keep that dialogue open with that…	5	35, 37-50	Suicide prevention.
M Is there anything that would remain unsaid to the client, anything that would be going on for you that you wouldn't be congruent with? P …I guess my sense of panic… M Yeah P …'cause that would be there, course it would… M But you wouldn't want to show that to the client? P …I'd have to think about it… I think I might do actually… M That you might actually share… P Actually I'm really feeling uncomfortable about all of this… M …this is how… P …it's really hard for me… M Yeah	5	36, 22-49	The Swan'. Congruent concern'.

P …for me too…			
M Mm			
P …yes, I think I might do…			
P Mmm… Yeah, because… I mean, there's two words coming up for me and one is 'equality', you know, I have feelings too…	5	37, 16-31	Congruent concern'. Challenging with the ripple effect
M Mm			
P …and they need to know that… and sometimes they can put… you know… that is an example of how that… they may put other people into other people into places that that other person feels uncomfortable with, so there's that learning for them… erm… and the other word… was- well actually it's two but 'I'm a human being too and I react' which is the same thing really…			
M Yeah			
P …I react to your actions… and you need to know how I react to your reactions…			
P So in a way then, isn't that… very, very… subtly saying to the client… that they- […] still thinks there's hope for me yet… to carry on from this place onwards and to grow and develop and learn…	5	38, 1-3	Congruent concern'. Value of offering space to speak about suicidal thoughts
P …I've always felt warm towards and you know, ok with that client… but I know what you mean it's like a contradiction almost like I'm saying I'm paying lip service to… yeah, you can take your own life if you like, that's fine… but actually I really don't want you to…	5	38, 38 - 40, 5	Client autonomy. Suicide prevention. Consequences of client suicide- professional and emotional.
M Yeah			
P Yeah. It's like a… a belief as opposed to… my own personal desire…			
M Can you perhaps explain that a little bit more?			
P …If I read about somebody who committed suicide in the paper… I suppose I wouldn't know that person…			
M Yeah			
P …and so I could say that that was their choice…			
M Mm			
P …but maybe as I grow to… and I use this term 'love' very loosely…			
M Mm			
P …as I grow to understand them better…			
M Yeah			
P Then maybe I become more selfish! (laughs)			
M So you're saying it's because I've actually formed some- perhaps I shouldn't use the term 'attachment' but er… but you have a feeling towards this client, you have a relationship with them…			
P Yeah			
M …and it's almost… are you feeling selfish, well actually, don't go because it will impact on me?			
P Yeah! (laughs)			
M Don't die because I'm going to feel bad…			
P Yeah (laughs) 'Cause of all the consequences for me! (laughs)			
M I believe you've got the right to do that, but don't do that because I'm going to feel bad			

P …and I think, you know, particularly for those maybe that have just come from school and they've been used to being looked after and… M Right P …and controlled, there's, there's a fine line here I'm treading, we're not talking about someone who's had their own freedom and total responsibility… M Mm P …and so, there's a sense of like… particularly if I know this client already… erm… I'm, I might be sort of… well is this person actually fully responsible for themselves and what input do- so I'm making a judgement call all the time with each and every one… I also deal with students with special needs…	5	41, 13-28	Perceived vulnerablity of young people
P …so like for example I- you know, I may have a client who, who's part of her- his or her, learning disability may well be involving memory loss, so you know, should I send them a text maybe an hour before their session here… M Mm P …to jerk their memory, you know… 'oh yes, I've got to see […] today or not'… erm… if a student ever asks me will I do that, I go down the route of why? What would we- why do we need to do that, is there any way that we can get you to do that for yourself, 'cause I don't really necessarily want to have to do that, it's an extra burden on me…	5	41, 37-48	Feeling some responsibility for the suicidal client. Client autonomy.
P Right. Ultimately, if it's blatantly clear that this is a suicidal client with absolute plan and intent then I have to take that responsibility off them- in this organisation- because my contract is clear about that… M Mm P …and I'm clear where I am in my employment here…	5	43, 41-47	organisational safeguarding policy. Suicide prevention. Working context, the effects of.
P …'cause I'd already been in touch with her GP and said, you know, I'm really concerned about this person, your patient erm… and he arranged to see her the following day and then it went from it… she wasn't really confident about how the doctor had dealt with her, that's when I ended up speaking to the […] team and actually I talked a lot about that with my supervisor and… in the end I knew that she was pulling my string- this client was pulling my strings and sort of going down that same route and I realised I'd done it three times, I'd 'jumped' and taken responsibility… M Right P …and when she did it again… instead of jumping up and doing something… I sat back and said… 'ok, what are you going to do about it then'… M Right P …and that changed the dynamic, the relationship… M Right. 'Cause my next question was actually going to be 'how effective do you feel it is to take that responsibility?' P It's not. That- those are… now, in that experience that wasn't… M Mm P …and I know probably… the reason that I responded like that with that client was because of her youth… M Mmm P …and her vulnerability M So you felt more drawn to take that responsibility… P Yes M …you didn't feel that she had the responsibil- or was able to take it for herself and yet after the third sort of time…	5	45, 18 - 46, 6	Holding the situation- not breaching according to contract. Perceived vulnerablity of young people. Is taking responsibility effective?

P I literally did- instead of moving forward in my chair… M Mmm P …I literally remember thinking 'we're at this point again… and I'm going to be different' M Mm P …I literally sat back in my chair and I did that (sits back and puts arms in lap) 'ok, what we going to do about that then'… M Mm P So I just literally just pushed it back on her but it… it took me a while to realise I needed to do that… M Yeah P …to get her back into taking responsibility… and I have since that point actually, 'cause I'm still working with her, she's still- she came through this summer and she's still working with her, I saw a change in the dynamic and in the relationship and she's much more well now, much more well and we are coming to the end of our work M So you're saying it feels like to you actually, actually, throwing that responsibility back on her… I'm almost getting the sense of actually TRUSTING her… P Yeah… yes… M …and her autonomy… P Yes, yes… M You feel that actually that has actually worked in that sense? P Yeah, yeah…	5	46, 20 - 47, 7	Responsibility transfer. Trusting the client, difficulty of
P No, it's quite interesting that. I like that idea or that I'm interested in my conflict between, yes, the client has their choice to take their own life- no hang on a minute, how's that going to impact on me…	5	48, 18-20	Client autonomy. Consequences of client suicide- professional and emotional
M How do you think, sort of… your responses to this would compare to those that other counsellors- what do you think they might say, might have said? Would they have given much the same or do you think they would have differed? P …Well I guess… …I guess if… it depends on their training, is what I'm going to say now… M Right P Erm… M Different therapeutic approach? P Yeah, possibly be different… and also their organisations that they work in will make them work very differently. One of my close friends is a counsellor in a very different type of organisation and it's within the NHS and there… very much more rigid and less flexible in their way that they work… their procedures are much more rigid… M Mm P Because, you know, those procedures are probably not driven by counselling professionals but more general health professionals and they're broad policies written for that environment…	5	48, 39 - 49, 13	Working context, the effects of.
P …and the clients that I get have already been screened and assessed as suitable for counselling… M Right P …the… the policy governing er… sort of risk, is… that… if I erm… think a client is at risk of harming themselves, I have to… I share that information,	6	3, 22-31	organisational safeguarding policy

erm… with either the mental health team leader, erm… or I may… er refer to the… client's GP. So it's a multidisciplinary team if you like			
P …I suppose what I do in practice… is that… I what is it? Make a risk assessment. I look at whether clients are presenting with suicidal thoughts… where there's no intent to do it, it's just a kind of method of, a fantasy of escaping whatever difficulties they're in… M Yeah P …erm but I… check out whether there's any intention to act upon those thoughts and at that point if I think there is then I would- I would either revert back to the mental health team or to the client's GP, whoever is available… M And is that kind of you doing that on your judgement or is that what the policy states that you do? P D'you know, being brutally honest, I don't know what the policy states, I think… there is a policy to refer back to, either the mental health team or the GP, erm… …if what you're asking is that kind of… erm… based on whether I think somebody is having suicidal thoughts or is- or there is some intent to commit suicide, I don't know what, I don't know if there's a distinction going on… M I suppose what I'm wondering is, erm, you know, is it the case that the policy says, you know, if the client says this, you do that, and therefore, you know, that's almost kind of out of your hands, you have to follow what the policy dictates or whether it's left up to your judgement to decide whether you breach that confidentiality… P No, if there's risk there, then I have to breach the confidentiality M And that's risk of intent rather than ideation? P Yes	6	3, 47 - 4, 29	Assessment, dialogic and continuous, client's 0-10 rating
M Ok, that's fair enough. So you, erm… you were saying sort of in the primary care service you're getting, you're getting people referred through who've already been screened, assessed… P Yes M …and then… from what you're saying you kind of, you almost risk assess yourself? P Yes, I do M …after that… P I do, I always risk assess in the first session, and ongoing if somebody's sort of presenting of being kind of hopeless or helpless or, you know, yeah, I do, I think er… M So how do you go about that, what sort of process do you use? P I… I would ask in the first session if… whether there was any… suicidal thoughts… whether they'd erm… whether there was any risk of them harming themselves, I would ask that as a question… M Yeah. So you would actually, you would broach the subject? P …Not… always, I think it would depend on the client and how they're presenting but if I- if I had a general sense of some kind of… M So you would, certain things would flag it up for you? P Erm… yeah, I think things like helplessness, hopelessness… M Mm P Things like social support, lack of, you know, isolation, erm… guess there would be a number of things that might…	6	4, 37 - 5, 23	Assessment, dialogic and continuous, client's 0-10 rating. Uses awareness of possible risk factors in assessing.
P Yeah, I've… I'm… under the IAPT… M Yeah P …stuff, we… are obliged to ask at every session, clients to fill in sort of erm… anxiety, personal health questionnaire form…	6	5, 43 - 6, 7	Required to risk assess with forms every session (IAPT)

M Yean P ...one of the questions is... whether there's... whether they've thought that they would be better off dead... M Yeah, so that's a fairly regular thing under the IAPT? P Yeah, every session			
P My contract working in the PCT is a verbal contract... M Mm P ...yeah, I contract with them usually at the beginning of the first session and erm... in terms of, sort of confidentiality I make explicit that if they were coming in... erm... and I felt that they were at risk of serious harm then that would be something that I would share with the mental health team or their GP M So you put it in those terms, sort of, risk of serious harm? P Or suicide? M You name it? P Yeah, I do say suicide, yeah... yeah... M And so you say that you will, you will share it or that you may, or... P I... I will share that information erm... and I would hopefully get their consent to share that information, erm... but there may be times when I might have to share that information without their consent...	6	7, 4-26	
P Erm... I think it's a re- it's a really difficult erm... thing to have erm... I think ultimately... I... I respect... a person's choice... M Yeah P ...in... in, you know, we- as human beings we have a choice, we have... free will... so... to that extent I, you know, I might think that it's ok for someone to commit suicide because that's there choice... M Yeah P Having said that, erm... you know, I think (laughs) I think people can make wrong choices and I think people can... you know, knowing that mind sets and feelings can change... that somebody choosing to commit suicide at a certain point when their life feels too difficult to handle, erm... things might change for them down the line and... and having committed suicide then it's too late and nothing can be done then, so...	6	7, 44 - 8, 12	Client autonomy. Rational/ irrational suicide.
P ...and as a counsellor, erm... again, I suppose I... have that view that... you know, respecting somebody's... erm... human rights I guess, erm... perhaps I can see that it's, it's somebody's it's a person's choice... to... to commit suicide... but I wouldn't want them to do it- whilst they're in therapy with me! (laughs)	6	8, 16-20	Client autonomy. Suicide prevention. Consequences of client suicide- professional and emotional
M What do you feel the role of counselling with suicidal clients is? What do you feel counselling can offer them? P ...uhh... hope... I think... and... empowerment to... for them to see... hope and see the chance for change...	6	8, 27-31	Value of counselling in offering hope and empowerment
P ...ah... I guess I wouldn't say that I would actively direct someone away from... M Yeah P ...away from that choice... but I think implicit in the work I do would be to explore whether that was the only choice that they had...	6	8, 41 - 9, 18	Value of counselling in exploring options other than suicide

M Mm

P Erm… yeah…

M I suppose it's sort of, it felt like from what you were saying about sort of, you know, hope and you know, that kind of thing that… erm… perhaps you would be hoping that by working with them in that way that they would sort of come through and not ma- not see that as a bad choice or choose a different choice…

P Yes…

M …even though you wouldn't be directly steering them…

P Mmm

M …down that route, you would be hoping that by working with them that would be the outcome possibly…?

P Yeah, yeah…

M Yeah, ok. What sort of impact did erm… your counselling training have on your own beliefs around suicide if it did have?

P Erm… I wouldn't say that it did

M So it didn't actually sort of… going through that training didn't really alter what you…

P I don't think it did, no…

M Was it actually covered as a subject in your training?

P Erm… gosh, asking me to think back now…! (laughs) Ten years or whatever… erm… think it probably was, perhaps not in any great depth, 'cause I'm just thinking I've done workshops and things around it since…

M Yeah

P So I don't think it was a massive part of the training…

M Did it feel was adequate?

P Probably not, no

6	9, 20-42	Vague memories of training

P Probably not, I think erm… having said that, I don't think anything can ever prepare you for… for working with a suicidal client, I think… nothing can take away the, the feelings that you have perhaps when you're working with a, you know… does that make sense?

6	9, 46-49	Nothing can adequately prepare you for a suicidal client

M …which is… this next section is when a client says that they're suicidal, what's going through your mind, what do you feel?

P Panic (laughs)

M Panic?

P Yeah… yeah… Oh my God! What do I do? I think that's… yeah… panic, horror… erm…

6	10, 14-22	Initial panic/ anxiety

P Because I… would, I don't want them to commit suicide, I think ultimately, you know, I think, going back to what I said, it's kind of… although… I… I might… erm… you know, accept everybody's got… a right to choose… er, and everybody's responsible for their own actions, whatever, that ultimately, whatever, I don't want anybody to commit suicide while they're on my watch if you like…

6	10, 26-31	Client autonomy. Suicide prevention. Consequences of client suicide- professional and emotional

P I think it's… 'I need to do something' or… or, yeah, 'what do I do… where…' I suppose it's a little bit kind of… also I guess a little, feeling a little bit helpless as well, which kind of reflects where the client is as well, feeling helpless…

M Mm. What do you… what do you feel and think about the client, I suppose… or feel towards…?

6	10, 40-48	Feeling helpless, 'what do I do now?' Empathic response.

P	Erm… compassion…		
P	…it's… I guess it's difficult… …I suppose possibly… anger… almost a sense of… erm… kind of… don't you dare have that attitude or don't… erm…	6	11, 6-28	Don't you dare do this to me- I'll feel bad! Consequences of client suicide- professional and emotional. Client suicide as a professional failure
M	So where's that anger coming from?			
P	I don't know, I'm just… I don't know… Something that came up as you were s…			
M	Don't you dare…			
P	…I think probably that, you know… you can't do this whilst… you're in therapy with me… I… I don't know, probably…			
M	Because…? If you do do it when you're in therapy with me…?			
P	…I'm going to feel… guilty… responsible (laughs)…			
M	Yeah… So it would feel like their death was your responsibility?			
P	I guess, yeah… yeah… Yes… erm… that I hadn't done enough to… help them, that I wasn't… I wasn't competent enough, I wasn't professional enough, I wasn't good enough			
M	…if I don't actually prevent you from doing this… it's going to feel like a failure for me…	6	11, 37 - 12, 37	Client autonomy. Feeling some responsibility for the suicidal client. Cognitive/ emotional split. Wanting to do more. Have I done enough?
P	Yes, and that's going to be down to me… and you can kind of… you know, I can think that and at the same time hold onto the idea that it's, that… their choice to do something- it isn't my responsibility…			
M	Mmm			
P	Erm… I guess ultimately it's about me… I don't know… I… I suppose with my experience…			
M	Mm			
P	…with a client… erm, ending his life… even though I know cognitively that I did everything that I could…			
M	Yeah			
P	…and I, you know, I adopted the correct procedure and…			
M	Mm			
P	…and actually you know, he'd been kind of referred back and seen his GP and… and, you know, that was that… I still felt some responsibility, I still felt… should I have done something else in the session, should I… could I have said anything else in the session that we had… erm… ultimately I don't think I could, I think I…			
M	Mm			
P	…you know and I… having explored it later in supervision, I really don't think I could have done anything different and if it happened again today I don't think I would do anything differently…			
M	I almost get the sense of there being two different levels, it's on the one hand it's the client's choice, it's their responsibility, I've done everything I can… and, and you can sort of rationalise that, talk through it and get the reassurance I guess from the supervisor, and yet on the other hand the feelings seem to suggest that you still feel… I don't know if responsibility's the right word, but its still feels as if…			
P	Yeah			
M	…maybe I could have, should have…			
P	Yeah			
M	…done something… else…			

M Yeah. What are you feeling, thinking about yourself as a counsellor when that client's saying they're suicidal? P ...am I... professional enough, am I competent enough, am I enough, can I... M You're questioning yourself as a professional, am I... up to this? P Yeah, I... yeah, this is, this is a, you know, a big issue and you know, am I going to be able to... am I good enough...	6	13, 1-10	Am I good enough? Being a responsible professional.
P Yeah... maybe not ultimately stop them from doing it... in fact I actually hadn't thought about that before, I think... that I think it's... for me it's sort of... it's almost like... it feels like I need to... help them put the brakes on it if you like, if they're on this journey... M Yeah P ...towards ending their own life... M Yeah P ...it's... it's almost as if I have to kind of help them put the brakes on to give them time to maybe obtain a different perspective on things... M So it's not necessarily stopping it but... actually what's slowing things down enough that they've got... an opportunity to reflect on what they're doing... P Yes, sort of... yeah, it... I think that would... that would explain it, yeah... kind of putting the brakes on and allowing them to... to explore other avenues, to think about... other- yeah, to perhaps gain a different perspective	6	13, 35 - 14, 8	'Putting the brakes on'
P ...that's exactly right and not necessarily it's something that they're rushing into, 'cause it could be a client that's sitting in front of you that's had years of distress and... you know... sort of- and maybe this decision, you know, is something that's been there for a long time for them but again, it might be again that they've been stuck with... yeah... looking with tunnel vision if you like... and it's about allowing them... to, to not have that tunnel vision and to widen their... perspective if... to sort of explore that anyway...	6	14, 49 - 15, 6	Holding the client, exploring options. Value of counselling in exploring options other than suicide
P Erm... may... I maybe the anger bit is not so much with the client but the... just a general kind of frustration that I'm in that... sort of area of panic... perhaps not... but how I respond to the client... erm... I think... I think the first thing is to kind of ground myself, erm... because I think when it...when it has happened you sort of you're kind of thinking and, you know, thinking about what you should be doing and whilst... trying to BE with your client... M Mm P ...and I think that's quite a tough thing and I hope, I hope that I respond... erm... with empathy and... with compassion and... you know, I hope I am... really hearing what the client's saying and I'm hoping that I'm reflecting that back, that I'm with them... M Yeah P ...and... erm... M It feels like that could be quite a struggle though from what you're saying because there's a lot going on for you there, you've tried to sort of put that... here's how I want to be responding to the client but it almost feels like you've kind of, when they've said that, you've suddenly become distracted maybe by all the stuff that's going on for you and then you're having to work harder to sort of somehow re-connect and... P That's absolutely right...	6	15, 27 - 16, 4	Initial panic/ anxiety. The Swan'.
P Yeah... erm... because obviously, the last thing I want to do if I'm feeling panicked inside, the last thing I want to do is show that to the client, erm... M Yeah P You know, I want to remain calm in front of the client and...	6	16, 9-37	The Swan'.

M Mm P …almost there's this kind of erm, you know there's the panic inside and thinking what to do… and almost… and then to the client… wanting to come across as… calm and… understanding and… er… professional in that I know what to do in these situations and you know and I… M Mm P …and obviously I'm having to… something about timing as well, you know, maybe having to say to the client that I'm really concerned about what you're telling me and… I feel that I might need to share this with someone, how would you feel about that, you know if I need to speak to the mental health team, erm… so there's all, it, it's a struggle I think to kind of… erm… sort of have… I'm just thinking it's almost like the… you know the swan… kind of on the surface appearing very serene to the client… M Mm P …but underneath, you know, kicking like crazy… P Mmm… erm… obviously I… hopefully let the client know that I'd heard what they'd said… M Yeah P …that I recognise that things were… felt so… hopeless that… perhaps suicide felt the only option at the time… that that caused me concern, that I was… I felt ethically obliged to, er… to take it further that… erm… you know that I'm also bound by… which I would have contracted with them in the first session… M Remind them of… P …I would have reminded… M …the contractual boundaries… P …them of what we'd talked about, erm… perhaps in the first session, whether we'd revisited that… M Mm P …so yeah, so I would remind them of my sort of ethical and professional obligations… erm… and… I mean ultimately, I guess, erm.. what happened in the situation with the… client who did commit suicide I… got him… I took him and got him an appointment with his usual doctor, erm… I also erm… you know, I was aware of his sort of… social environment if you like and his sort of family environment, erm… so… before he had the… appointment with the doctor the following day I… suggest that if he felt at risk he attend A & E…	6	17, 7-36	Congruent concern'. Empathic response. Referring back to the contract as issues arise.
M Ok. Does anything remain unsaid to the client, is there anything going on for them that you don't communicate to them? P …I suppose… erm… it's around… that suicide doesn't have to be… the only option, that there, that… something about… I hope you get to a point where you can see a wider perspective…	6	17, 49 - 18, 4	Holding the client, exploring options. Suicide prevention. 'Putting the brakes on'. Value of counselling in offering hope and empowerment
P …I think he… said at the end of the session that it had… he'd been pleased that somebody had finally listened to him… M Yeah? P …which… you know, that kind of gave me some comfort, that he'd felt heard…	6	18, 15-21	Value of offering space to speak about suicidal thoughts
P Erm… I suppose I… yeah… But yeah. I suppose it… yeah, it… it could well be something that I would say to a client… M …that your hopes for… P Yeah… that… that my hopes for therapy would be that… M Mm P That they may gain some kind of different perspective on their life… M Yeah… So it feels as though that is maybe… as you say, you can accept their… their choice in… wanting to end their life but your hope for working with them is that perhaps it will…	6	18, 25 - 19, 2	Congruent concern'. Value of counselling in exploring options other than suicide. Holding the client, exploring options. Suicide prevention. 'Putting the brakes on'.

P	Yeah			
M	...enable them to come through that and perhaps choose a different path...			
P	...and you know, accept how desperate things are for them and kind of, you know... yeah... rather than make them feel that, oh, you know, things aren't that bad, you know. I think it's about accepting where they are now... but with the hope of...			
M	Mm			
P	Things changing in the future			
P	Yeah... and I suppose in a way... to... erm... to gain, get some reassurance as well that I'd... been all that I could be or done everything that I could...	6	19, 30-43	Supervision as reassurance.
M	So you're using them almost to check out that anxiety about 'am I good enough'...			
P	Yes			
M	...'am I up to this job'... 'have I done everything'...			
P	'Have I done everything'... yeah, 'was I enough for this client'... yeah, so I'd definitely say it's a kind of offload and a, and a reassure... you know try and get that reassurance...			
M	It feels like... it almost feels as though there's that... it almost feels as though you're feeling perhaps burdened with something... in working with those kind of clients...?	6	19, 7 - 19, 26	Feeling some responsibility for the suicidal client. Being a responsible professional.
P	Definitely			
M	How would you describe that... something that... that burden if you like...?			
P	Er... (sighs) ...I think it's about... erm... think it's that kind of feeling of responsibility again... erm... that... yeah, the feeling of... suppose this client's... not just this client's wellbeing but this client's life...			
M	Mm			
P	...is in my hands or... you know that... in a way, you know, that I'm... that I'm responsible for... I think I do... I think it's that feeling of responsibility towards and... suppose it's that difference isn't it between acting... responsibly towards a client and feeling responsibility for them...			
M	Yeah, yeah... and it's interesting that you bring that word up because that's the final section, I mean it almost... I got this image in a way, when you were describing that burden in a way, I almost get this sense of almost the client kind of... what's actually going on metaphorically is almost like the client kind of... saying 'here you go'... (gestures handing something to the participant)	6	20, 28-47	Responsibility transfer. Sharing or passing on the burden of responsibility.
P	Yeah, yeah			
M	...there you go, it's your responsibility now and you're going 'whoa! What do I do with this?' and then you're kind of... thinking yeah... how do I actually deal with this and then you're off to supervision saying 'I feel like this, have I dealt with this right'			
P	Yeah			
M	...and then almost trying to offload that onto the supervisor, it's almost like pass the parcel kind of...			
P	It is, yeah, it is, it's almost like a dumping isn't it?			
P	Gosh... that's really interesting isn't it, 'cause just as you were asking that question I was thinking ordinarily with clients I don't feel any- I act responsibly towards them...	6	21, 17-29	Feeling some responsibility for the suicidal client. Client autonomy.
M	Yeah			
P	...but I actually don't feel responsible for them...			
M	Mmm, and that's an interesting distinction as well...			
P	...and I don't feel responsible for clients because ultimately they're responsible for themselves but it's interesting having just talked about suicidal clients that I feel much more responsible for them...			

M Erm… but you're feeling really well, no, that's their life, their responsibility, I'm a responsible professional… P Yeah M …but they're responsible for their life… BUT, when they tell me they're thinking of ending their life. suddenly… P Yeah, yeah… M A proportion of it passes to you… I mean could you quantify it in any sense or… 'cause it feels like… some or all passes onto you, something passes on to you… P Not all, but I would say… I would say certainly some… I would find it hard to quantify really… M Hard to quantify… P …but definitely… M …but you can feel some… P Absolutely…	6	21, 41 - 22, 14	Client autonomy. Being a responsible professional. Feeling some responsibility for the suicidal client. Responsibility transfer.
M A taking on of… I suppose what just occurred to me then was, does it feel like this is something you're taking or something that the client is giving you? …Or is it both? P Probably I would say I think the client's giving and I'm willing to take… M Mmm P …whereas I think other clients are willing to… try and give the responsibility to me… M Mmm P …but I'm not willing to take it…	6	22, 16-29	Responsibility transfer. Feeling some responsibility for the suicidal client.
P …and I'm taking it… and I'm feeling, yes I'm feeling some kind of obligation, yeah, yeah…	6	23, 1-2	Feeling some responsibility for the suicidal client
P Ultimately I… I guess a suicidal client is just like any other client, the… the issue… is different… but I… I… yeah, I suppose if I was treating them like any other client I suppose I wouldn't be taking any responsibility for them…	6	23, 7-10	Client autonomy. Feeling some responsibility for the suicidal client
P Because it depends what you mean by effective… M Yeah… and I just, I thought that as I asked that, 'cause it almost depends on what you think the outcome should be… P Exactly, if… the part of me that says it's every person's human right to… you know, we've got choice… I might think one way and… you know… the professional in me that wants to stop somebody from… M Mmm P …committing suicide might… M So there could almost be two, it would depend on what the goal you thought it was, if the purely, let's say person-centred goal could almost be phrased as 'well if suicide is the right thing for them'… P Yeah M …and actually, I mean you've explored everything and they choose that- that's been effective, but if actually the goal is to sort of maybe let them look at that fully but then choose a different path, the goal would be a different thing really… P Mmm	6	23, 33 - 24, 7	Is taking responsibility effective?

P I guess if you're taking responsibility for a client… that goes against the idea that you want to empower your client…	6	24, 15-16	Feeling some responsibility for the suicidal client. Client autonomy. Value of counselling in offering hope and empowerment.
M 'cause it certainly feels like that's obviously what's going on for you, and I guess that's where, you know, this is what I think is interesting about this issue is it's sort of… if that's what's going on and that's what you're feeling… you should do… you know, is that actually, you know, what is the effect of that, even if you want to put it in more neutral terms, what's the actual effect of actually taking on that degree of responsibility…? P Mmm… I guess you… potentially disempowering the client… M Mmm… can you see any circumstances where it would be… I don't know, where there would be a positive side to it, or…? P Erm… yeah… you might stop somebody from committing suicide… 'cause my… feelings of responsibility have led me down a… path of… getting them further help or…	6	24, 42 - 25, 6	Client autonomy. Value of counselling in offering hope and empowerment. Suicide prevention.
P Yeah, I think, you know, when you're… when you've got a very vulnerable client sitting in front of you… M Yeah P …erm… it, it would be the right thing to do to take some degree of responsibility for them… M Mmm… So I suppose we can say in general terms maybe, at times it's the right thing to do but then it almost feels like we can't really quantify that… P No M …we can't prescribe… P No M …when and where that should be… P No M …but there may be times when it's… P Mmm M …Yeah… P Yeah…	6	26, 13 - 26, 41	Taking responsibility is justified by the client's vulnerability
P …the layering, I think that's the thing that's the biggest thing that's come out of it… M Mm P …erm… the sort of difference between… erm… yeah, the… the different layers, I think that's the thing that's been highlighted for me… M Yeah, and that would be a cognitive and an emotional? P Yes, yeah…	6	27, 11-21	Cognitive/ emotional split

Appendix IX: Outcome Propositions/ Categories and Themes

Outcome Propositions/ Categories and Themes		
No.	**Category Name and Rules of Inclusion**	**Themes/ Provisional Categories**
1	**A respect for autonomy, and an awareness of risk but it still may not be enough...: The impact and limitations of training and experience** Counsellors found it difficult to recall their core training with respect to suicide other than giving them a respect for clients' autonomy. Post qualification experience and training was felt to have had more influence but could still be felt to be inadequate when faced with a suicidal client.	Post qualification training in suicide
		Vague memories of training
		Value of training in recognising we can't know how others feel
		Client autonomy.
		Training facilitated exploration of issues without being directive
		Nothing can adequately prepare you for a suicidal client
2	**Protective framework or restrictive constraint? The impact of organisational context, policy and procedure.** Counsellors have to work within the context of organisations with their own needs and priorities. These impact directly on decisions counsellors have to make around breaching confidentiality when working with suicidal clients.	specific written contract
		Working context, the effects of.
		Other support involved can make the situation complex.
		organisational safeguarding policy
		Conflicting policy demands
		Formal contracting
		Not avoiding the term, being specific.
		Required to risk assess with forms every session (IAPT)
		Referring back to the contract as issues arise.
		Danger of complacency in outlining boundaries
		Verbal contracting in crisis situation, paperwork inappropriate
		The reassurance of policies and contracts
3	**The Swan moment: Counsellors' thoughts and feelings when a client says they're suicidal** Counsellors experienced a distinct cognitive/ emotional split between feelings of panic, anxiety and helplessness and thoughts of what the situation demanded of them as a professional. This potentially threatened to disrupt their natural empathic connection to the client.	‘The Swan'.
		Anxiety-driven exploration of extent.
		Initial panic/ anxiety
		Feeling helpless, 'what do I do now?'
		Opening a can of worms.
		Life and death, finality.
		This is going to be hard work…
		Empathic response.
		Glad they've shared suicidal feelings.
		Cognitive/ emotional split
		'The emotional contract' - betraying this
4	**I respect your autonomy, I just don't want you to act on it: Counsellors' perceptions of suicidal ideation in clients.**	Hard to empathise with suicidal feelings if you've never had them
		Trusting the client, difficulty of

	Despite believing strongly in their clients' autonomy, counsellors found it difficult to trust in, as they sometimes struggled to fully empathise with suicidal feelings even though accepting them as the client's reality. Their own personal and professional experiences can impact in this area.	Normality of suicidal ideation
		Rational/ irrational suicide
		They want to be stopped.
		Impact of own experience of suicide and of working with clients
5	**Assessment: Informed, dialogic and continuous.** Counsellors view assessment as a continuous, dialogic process, using their own skills and experience, sometimes informed by more formal tools**.**	Referral - no prior information
		Assessment, dialogic and continuous, client's 0 -10 rating
		Uses awareness of possible risk factors in assessing.
6	**I'm responsible to my clients, not for them- but when they're suicidal, I find myself feeling some responsibility: Responsibility for the suicidal client: where does it and should it lie?** Counsellors believe that clients are responsible for their own lives and they, as professionals, are responsible to them. However, when the client was suicidal, counsellors found themselves feeling and sometimes taking a proportion of responsibility, which they found difficult to quantify, or evaluate in terms of therapeutic effectiveness.	Feeling some responsibility for the suicidal client
		Is taking responsibility effective?
		Responsibility transfer.
		Taking responsibility is justified by the client's vulnerability
7	**It feels worse when they're young… The vulnerability of young clients** Counsellors feel young people are more vulnerable and less autonomous than adults, find them more challenging to work with because of this and feel a greater degree of responsibility both toward and for them.	Perceived vulnerablity of young people
8	**Being a responsible professional** Suicidal clients can make counsellors feel inadequate as a professional, that they need to do more in order to do enough and fear the emotional and professional	Being a responsible professional.
		Wanting to do more.
		I hope I can do enough
		I've got to work harder.
		Am I good enough?
		Have I done enough?
		'What if?' anxiety

	consequences of feeling or being seen to have done less.	Client suicide as a professional failure
		Don't you dare do this to me- I'll feel bad!
		Consequences of client suicide- professional and emotional
		A kind of vicarious trauma.
		I've given honest responses, would others?
9	**What I can offer to suicidal clients: space, hope and alternative options.** Counsellors feel that they can offer a safe space for clients to talk about suicidal thoughts, helping them explore options other than taking their lives and giving hope and empowerment	Value of offering space to speak about suicidal thoughts
		Value of counselling in offering hope and empowerment
		Value of counselling in exploring options other than suicide
		Holding the client, exploring options.
10	**Holding the situation within the boundaries** Counsellors can choose to continue to work with the suicidal client, sometimes contrary to organisational policy, on the grounds of their therapeutic approach and the ethical framework of their professional organisation but this feels risky to them	Holding the situation- not breaching according to contract
		Difficulty of breaching against client's wishes
		Justifying working to BACP guidelines instead of organisational policy
		Working within own professional boundaries and ethical code
		Concern that client will not continue because of confidentiality boundaries
		Use of hypothetical scenarios to illustrate confidentiality boundaries
		Being specific about self harm
		Being non-specific in contracting.
		The grey area
11	**Putting on the brakes and putting up the safety nets: Counsellors' actions when working with suicidal clients.** Counsellors channel concern for the client and their own professional anxiety into a variety of means of managing the risks to the client and also to themselves.	‘Congruent concern'.
		'Putting up the safety nets'.
		'Putting the brakes on'
		Challenging with the ripple effect
		Suicide prevention.
		Practical risk management
		Uncomfortable as a counsellor dealing with practical risk management.
		Covering the counsellor/ organisation, getting support for the client, even if not effective
12	**Sharing or dissipating the burden.** Counsellors sought to dissipate the burden of responsibility they can feel in working with suicidal clients by seeking reassurance and guidance from supervisors and, where appropriate, sharing concerns with supportive superiors.	Sharing or passing on the burden of responsibility
		Importance of good relationships with superiors.
		Supervision as a safe space
		Supervision as reassurance.